

Southwest Pediatrics

Hitesh Shah, M.D., F.A.A.P. Charity Santiago, M.D., F.A.A.P. Alan Dakak, M.D., F.A.A.P.

9802 Stockdale Hwy, Suite 103 Bakersfield, CA 93311

We would like to take the time to thank you for your patience as we transfer to our new Electronic Medical Records system. This new system helps us provide better medical care to your child.

To provide this service we are asking for your help in updating our records to reflect the most updated information for your child; also obtaining new information.

Our upcoming patient portal will allow you to obtain health information from home about your child. The patient portal will allow you to access items like lab results, immunization records, request appointments and make payments in reference to your child(ren). This new feature requires us to obtain your **email** address.

Some of the information being asked is part of the new health care reform requirements for the meaningful use of the electronic health records system.

We apologize for any wait longer than usual as we are transferring systems.

Thank you,

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Patient(s) and sibling(s) Names: _____

Living in the same house hold

Email Address: _____ Select: Mom/dad

Email Address: _____ Select: Mom/dad

Primary Language spoken in the home: _____

Secondary Language spoke in the home: _____

Patient's Ethnicity: Hispanic or Latino Not Hispanic or Latino

Patient's Race(s): *American Indian or Alaskan Native Asian Black Hawaiian Native or Pacific Islander White*

Mother's employer: _____

Mother's occupation: _____

Father's employer: _____

Father's occupation: _____

Who would you like to be assigned as the preferred Method of contact for the patient's medical issues, reminder calls, statements ETC.

Relationship to the Patient: _____

How you would like them to be contacted: *Please circle one method of contact*

Medical issues: Home Phone Work Phone Cell Phone Email

Reminders: Home Phone Work Phone Cell Phone Email

Recalls: Home Phone Work Phone Cell Phone Email

Patient Portal: Text to Cell Home Email Work Email

Contact Privacy Restraints *Please Circle one of the following*

No Restrictions: OK to send messages/mail **Restricted:** Person-to-person/guardian only **Restricted:** Other

Permission to submit vaccine information to local immunization registry YES NO

Preferred Pharmacy and location
