Pediatric Clinic Telehealth Services Registration

Date: _____

Dear Parent/Guardian,

We are pleased to offer telehealth services for your child's healthcare needs. Please complete the registration form below to ensure a smooth process for your upcoming virtual visit.

Patient Information

Child's Full Name: _____

Date of Birth: _____

Gender: _____

Parent/Guardian Information

Name: _____

Relationship to Child: _____

Phone Number: _____

Email Address: _____

Telehealth Preference

Preferred Date and Time for Appointment: _____

Platform Used (Zoom, Skype, etc.): _____

Insurance Information

Insurance Provider: _____

Policy Number: _____

Once completed, please return this form to our clinic via email or fax. Our team will reach out to confirm your appointment.

Thank you for choosing our clinic for your child's healthcare needs.

Sincerely,

The Pediatric Clinic Team