



TRESTLEWOOD PEDIATRICS

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TRESTLEWOOD PEDIATRICS PATIENT PORTAL REQUEST

Children, ages 14 and under

Complete the following information to receive an invitation to your patient portal.
Please write legibly!

Email address: _____

First Name: _____

Last Name: _____

Date of Birth: _____

Zip code: _____

Please give completed form back to a staff member once complete.

If you are a *parent* requesting an invite, please list the names of the children for which you like access
(note: adolescents ages 15 and older are advised to establish their own account)

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

You will receive a "Portal Invite" to the email provided above within 1-2 weeks.
If you do not receive the email, please contact our office. Don't forget to check your spam folder.

Please be aware that there may be some glitches as we start this process.
Do not hesitate to call us if you have any questions.

----- for Staff Use Only below this line -----

Portal Invite sent on _____ . Performed by _____ .
Date Initials