TRESTLEWOOD PEDIATRICS

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TRESTLEWOOD PEDIATRICS PATIENT PORTAL REQUEST

Patients, ages 15 and older
(Adolescents ages 15 and older are advised to have their own account)

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: _____

(optional) ☐ I, _____ (first and last name), authorize my parent(s) _____ (parent(s) name(s))
to be granted access to my Patient Portal account.

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

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.

Do not hesitate to call us if you have any questions.

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

Portal Invite sent on _____ (*Date*). *Performed by* _____ (*Initials*).

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