

HIGHLANDS PEDIATRICS, PC

*PARENT OF NEW CHILD: WELCOME!
PLEASE COMPLETE THIS FORM FULLY & GIVE TO YOUR NURSE
THANK YOU.*

Child's Name: _____

Mother Information

Name of Mother: _____ Date of Birth: _____

Mailing Address: _____

Street Address: _____

Soc Sec No.: _____ - _____ - _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Employer: _____ Work Phone: (____) _____ - _____

Father Information

Name of Father: _____ Date of Birth: _____

Mailing Address: _____

Street Address: _____

Soc Sec No.: _____ - _____ - _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Employer: _____ Work Phone: (____) _____ - _____

Legal Guardian Information

Name: _____ Date of Birth: _____

Mailing Address: _____

Street Address: _____

Soc Sec No.: _____ - _____ - _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Employer: _____ Work Phone: (____) _____ - _____

Relationship to Child: _____ Were You Appointed By a Court? Yes No

If So, Which Court? _____ When? _____

If You Are Employed Outside the Child's Home, Who Cares for the Child While You Are Away?

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

In Case of an Emergency, Whom Should We Contact?

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Please List the Name of Any Person ("Agent") that You Wish to Appoint to (i) Receive Medical Information About the Child, and (ii) Authorize Medical Treatment for the Child as Such Person Deems Appropriate After Consultation With Our Staff in the Event That You Are Unable to Accompany the Child to this Office or the Hospital.

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Name: _____ Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

As the Parent or Legal Guardian of the Child, I agree that I have completed this form to the best of my knowledge. I hereby appoint each Emergency Contact and Agent named above to authorize and consent, both orally and in writing, to such medical treatment for the Child as may be recommended under the circumstances then existing, and any medical provider will be deemed to have provided care to the Child with my express consent and direction in such event.

Signature of Parent or Legal Guardian: **X** _____ Date _____

HIGHLANDS PEDIATRICS, PC

Child's Name: _____

Other Children in Child's Home

Name: _____ DOB: _____ Health Problems: Yes No
Name: _____ DOB: _____ Health Problems: Yes No
Name: _____ DOB: _____ Health Problems: Yes No
Name: _____ DOB: _____ Health Problems: Yes No

Child's Medical History

Where Was the Child Born? _____ Johnston Memorial Hospital
_____ Other: _____ City: _____

How Much Did the Child Weigh at Birth? _____ lbs _____ oz. Any Problems: _____

Name of Prior Doctor: _____ Location: _____

Has the Child Been Hospitalized Before? Yes No If So, Where? _____
For What? _____

Has the Child Had Surgery in the Past? Yes No If So, Where? _____
For What? _____

Does the Child Take Regular Medications? Yes No If So, What? _____

Is the Child Allergic to Any Medications? Yes No If So, What? _____

Sleep Problems? _____

Behavior Problems? _____

| | | | | |
|--------------------------|-----|----|------------------------------------|--------|
| Frequent Ear Infections? | Yes | No | If Yes, How Many in Last 3 Months? | _____ |
| Eye Problems? | Yes | No | Teeth Problems? | Yes No |
| Frequent Colds? | Yes | No | Frequent Sore Throat? | Yes No |
| Recurring Coughs? | Yes | No | Heart Murmur? | Yes No |
| Urination Problems? | Yes | No | Diarrhea or Constipation? | Yes No |
| Seizures? | Yes | No | Skin Problems? | Yes No |
| Low Blood Pressure? | Yes | No | Food Allergies? | Yes No |
| Good Appetite? | Yes | No | | |

Describe Any Medical Problems? _____

Family Medical History

Please Describe Any Health Problems (such as Diabetes, Heart Disease, Cancer, High Blood Pressure, Hearing Problems and Others) That Any of the Following Relative's of Child Have. You May Continue Any Descriptions on the Back of this Page.

Mother: _____ Father: _____

Sister/Brother: _____ Grandparents: _____

Does Anyone in the Child's Home Smoke? Yes No

What Is the Source of Water in the Child's Home? _____ Public Water _____ Private Well
_____ Other: _____

How Did You Hear About Our Office? _____

Name of Your Pharmacy: _____ Location: _____