# HIGHLANDS PEDIATRICS, PC

*PARENT OF A NEW-BORN – **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* _____

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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 Birth Problems:* _____
_____
_____

*Good Appetite?* Yes No *Food Allergies?* Yes No
*Problems With Weight Gain?* Yes No *Colic or Other Feeding Problems?* Yes No
*Breast Fed?* Yes No *If Not, Which Formula?* _____

*Describe Any Sleep Problems?* _____
_____
*Other 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:* _____
*Brothers/Sisters:* _____
*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:* _____