

**Highlands Pediatrics**  
Pediatrician: \_\_\_\_\_

Child's Name:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: **M** or **F**

Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Address: \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Social Security No#: \_\_\_\_\_ Insurance \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

ID# \_\_\_\_\_ Group No#: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Parents Info:

Father's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Address(if different): \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's

Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Address(if different): \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other Children In Child's Home:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact Info(Other than parent):

Name: \_\_\_\_\_

Ph No#: \_\_\_\_\_

Relationship: \_\_\_\_\_

**It is the parent's responsibility to keep this information current and updated.**