Hillsborough Pediatric & Adolescent Medicine, PLLC

Patient Demographic Form

Patient Information:

Child's Name: _____

Date of Birth: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip code: _____

Home Phone Number: _____ Alternate Phone Number _____

Parent/Guardian Information:

Name: _____ Relationship to Child: _____ Phone Number: _____

Occupation: _____ Work Number: _____

Name: _____ Relationship to Child: _____ Phone Number: _____

Occupation: _____ Work Number: _____

Pharmacy Information:

Pharmacy Name: _____ Phone Number: _____

Address: _____ City: _____

Treatment Authorizers:

Please list anyone, other than yourself, who is allowed to authorize treatment for your child.

Name: _____ Relationship to Child: _____ Phone Number: _____

Name: _____ Relationship to Child: _____ Phone Number: _____

Name: _____ Relationship to Child: _____ Phone Number: _____

Parent/Guardian Printed Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

1000 Corporate Drive, Suite 401 · Hillsborough, NC 27278 · Phone 919-245-3344 · Fax 919-245-3308
www.hillsboroughpeds.com