

# 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: \_\_\_\_\_

### Parent/Guardian Information:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone 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:** \_\_\_\_\_