PATIENT DEMOGRAPHICS

Father's name _____
Address _____
City, State, & Zip _____
Phone number (Home) _____
(Cell) _____
email _____

Mother's name _____
Address _____
City, State, & Zip _____
Phone number (Home) _____
(Cell) _____
email _____

I _____ (parent/guardian) give Pediatric & Adolescent Center, SC permission to leave messages regarding my child(ren)'s health, labs, billing, etc. at the above phone numbers and/or email addresses.

CHILDREN

Name	Birthdate	Sex	Allergies