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PEDIATRIC HEALTH CARE

42141 Mound Road, Suite B
 Sterling Heights, Michigan 48314
 586.254.7593
 586.254.7834 Fax

from infants to teenagers

YEARLY FAMILY DEMOGRAPHICS UPDATE

Home Address _____ City _____ State _____ Zip _____

Main Phone Number (Test Results/Reminder Calls): (____) _____ Texting Ability? Yes / No

Main E-mail Address _____

Please list all children in your family that are patient's at Pediatric HealthCare (Name & Date of Birth)

NAME	DOB	NAME	DOB

PARENT OR GUARDIAN INFORMATION

Last Name: _____ First Name: _____
 Relationship: Mother / Father / Other (Relationship to child) _____
 Address (if different than above): _____
 Phone (____) _____ Cell Home Work

Last Name: _____ First Name: _____
 Relationship: Mother / Father / Other (Relationship to child) _____
 Address (if different than above): _____
 Phone (____) _____ Cell Home Work

If there are custody arrangements, please notify front staff upon check in and provide documentation.

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ Relation: _____

Phone (____) _____ Cell Home Work

Is this individual able to bring your child(ren) to appointments? Yes No Parent/Legal Guardian Initial: _____
 Is this individual authorized to make medical decisions on your behalf? Yes No Parent/Legal Guardian Initial: _____
 Is this individual authorized to receive protected health information? Yes No Parent/Legal Guardian Initial: _____

I/We being the parent(s) or legal guardian(s) of the previously named minor child(ren) hereby acknowledge the information that is provided here is true and accurate.

 Parent/Guardian Name (Print)

 Parent/Guardian Name (Signature)

 Date