

**Pediatric Healthcare Associates of Waxahachie**

1710 W. Hwy 287 Business Suite 100

Waxahachie, TX 75165

(972)937-1221

(972)937-8934 fax

**PATIENT INFORMATION**                      Male or Female (circle one)                      Date: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**MOTHERS INFO:** Drivers License#: \_\_\_\_\_ Email: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell: \_\_\_\_\_

**FATHERS INFO:** Drivers License#: \_\_\_\_\_ Email: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell: \_\_\_\_\_

**EMERGENCY CONTACT** (someone not living in your household)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Work#: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

I certify this information is true and correct to the best of my knowledge. I agree to notify you of any changes in my status of the above information.

\_\_\_\_\_  
**SIGNATURE OF PARENT/GUARDIAN**

\_\_\_\_\_  
**DATE**