

Initial Date of Service: _____

DX: _____

SECTION I CLIENT INFORMATION

Child's Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ May we leave a message? Yes No

Cell Phone (_____) _____ Party _____ May we leave a message? Yes No

Cell Phone (_____) _____ Party _____ May we leave a message? Yes No

Date of Birth _____ Gender _____

School/Grade _____ F/T Student P/T Student

Referred by _____

SECTION II PARENT, GUARDIAN, AND FAMILY INFORMATION

Parents' Marital Status Single Married/Partnered Separated Divorced Widowed

Parent/Guardian 1

Parent/Guardian 2

Name _____

Name _____

Age _____

Age _____

Occupation _____

Occupation _____

Telephone _____

Telephone _____

Email* _____

Email* _____

Check here if we have permission to send email reminders for appointments.

**Please note: Email correspondence is optional and not a confidential medium of communication*

Please describe custody arrangements (if applicable): _____

Are there other relatives or adults that are important caretakers of your child (i.e. stepparent, significant other, grandparent, babysitter, etc.)? Please list:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

Please list information about your child's brothers or sisters below (please include stepsiblings):

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

Emergency Contact/ Relationship _____ Telephone _____

SECTION III INSURED INFORMATION (If Applicable)

Relation to client: Spouse/Partner Parent Other: _____ Self – Go to section IV

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

May we leave a message? Yes No

May we leave a message? Yes No

Date of Birth _____ Gender _____ Social Security Number _____

Employer _____

SECTION IV PRIMARY INSURANCE INFORMATION (If Applicable)

Please provide your insurance card and a photo ID to the receptionist

Insurance Company _____

Name of Policy Holder _____ Date of Birth _____

Is the patient covered by more than one insurance? Yes- Go to section V

No- Go to section VI

SECTION V SECONDARY INSURANCE INFORMATION (If Applicable)

Please provide your insurance card and a photo ID to the receptionist

Insurance Company _____

Name of Policy Holder _____ Date of Birth _____

SECTION VI RESPONSIBLE PARTY INFORMATION

Who is responsible for charges for this patient? Patient

Insured

Other- Please complete the following information

Responsible Person/Agency _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

May we leave a message? Yes No

May we leave a message? Yes No