Child and Adolescent
CLIENT INFORMATION

Name of Client:_____ Gender M____F____Current Date_____
Home
Address:_____City:_____State:_____Zip:_____

Home Phone:_____ School:_____ Grade Level:_____

Date of Birth:_____ Age:_____ Favorite Activity:_____

Referred to this office by:_____ Social Security #_____
Current
Medications:_____Allergies_____
Physical
Illnesses:_____Physician:_____

Emergency Contact_____ Phone_____

PARENT/GUARDIAN INFORMATION

Mother's name:_____ Social Security: _____DOB: _____Age:_____

Address (if different from above) _____City: _____State: _____Zip:_____

Home Phone:_____ Cell Phone: _____ E-Mail Address _____

Employer:_____ Work Phone: _____

Father's name:_____ Social Security: _____DOB: _____Age:_____

Address (if different from above) _____City: _____State: _____Zip:_____

Home Phone:_____ Cell Phone: _____ E-Mail Address _____

Employer:_____ Work Phone: _____
Other Siblings
Name:_____ Age:_____ DOB_____ Name:_____ Age:_____ DOB_____

Name:_____ Age:_____ DOB_____ Name:_____ Age:_____ DOB_____

INSURANCE INFORMATION

Primary Company:_____ Secondary Company:_____

Subscriber Name_____ Subscriber Name_____

Address_____ City_____ State_____ Address_____ City_____ State_____

DOB_____ Relationship to Patient_____ DOB_____ Relationship to Patient_____

Subscriber #_____ Subscriber #_____

Employer Group_____ Employer Group_____

Co-Payment_____ Co-Payment _____

(Initial Please) I do_____, I do not_____ want our family physician contacted by this office regarding your child's treatment here. If so, you must complete the following information. (All Physician fields below must be completed)

Physician_____**Address:**_____**City**_____
State:_____**Zip:**_____**Telephone:**_____**Fax:**_____