PSYCHOLOGICAL SERVICES OF PENDLETON, LLC.–CHILD INFO.

IDENTIFYING INFORMATION:

Name: First M.I. Last	Date of Birth	Soc. Security #	Age
Address			
City	State		Zip Code
Gender □Male □Female □Gender Fluid	School Name		School Grade

FAMILY/GUARDIAN INFORMATION:

	Name	Date of Birth	Home Phone	Can we leave a message?	Cell phone	Can we leave a message?
Mother				□Yes □No		□Yes □No
Father				□Yes □No		□Yes □No
Step-father				□Yes □No		□Yes □No
Step-mother				□Yes □No		□Yes □No
Non-Custodial parent:			Address:			

PRIMARY CARE PROVIDER:

Provider Name	Phone Number

PRIMARY INSURANCE COMPANY:

Company		Phone Number
ID Number	Group Number	Subscriber Employer
Subscriber's Name	Date of Birth	Patient's relationship to subscriber
Subscriber Address if different from patient:		

SECONDARY INSURANCE COMPANY:

Company		Phone Number
ID Number	Group Number	Subscriber Employer
Subscriber's Name	Date of Birth	Patient's relationship to subscriber
Subscriber Address if different from patient:		

My signature on this form authorizes contact with my dependent's doctor or primary care provider. My signature on this form authorizes the release of medical information necessary to process claims for my insurance company. My signature on this form authorizes payment of insurance benefits to the treating provider. Sending claims to my insurance company is a service provided by Psychological Services of Pendleton, LLC. By signing this form, I certify that I am legally responsible for any charges incurred by my dependent to this provider.

PATIENT SIGNATURE ***(if 14 years or older)*** **DATE**

PARENT/GUARDIAN SIGNATURE **DATE**

INSURANCE CO-PAYMENTS ARE EXPECTED AT THE TIME OF VISIT

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