PSYCHOLOGICAL SERVICES OF PENDLETON, LLC.–CHILD INFO.

IDENTIFYING INFORMATION:

Name: First M.I. Last	Date of Birth	Age	Social Sec. #:
Custodial Address:			
City	State		Zip Code
Gender □Male □Female □Gender Fluid	School Name		School Grade
Patient Phone Number (*14 years & older*) :			

FAMILY/GUARDIAN INFORMATION:

	Name	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

PRIMARY CARE PHYSICIAN:

Physician 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

135 SE First St. ● Pendleton, Or 97801 ● Phone: 541-278-2222 ● Fax: 541-276-8405
Email: psp@pendletonpsych.com