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Childs's Name: _____ Today's Date_____

Gender: ☐ M ☐ F Age: _____ Birth Date:_____ Soc Sec No:_____

Custodial Parent(s) Name: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Mother's Work:_____ Father's Work: _____

May we leave messages at home? ☐ Yes ☐ No May we leave messages at work? ☐ Yes ☐ No

Grade in School: _____ School: _____ Phone: _____

Referred by: _____

Others Living in Home (name, birth date, relationship to client): _____

_____

Immediate family living outside the home (name, birth date, relationship to client): _____

_____

Emergency Contact: _____ Phone: _____

Insurance Information Intake

Name of Insured: _____ Insured Date of Birth:_____

Address of Insured:_____ City, State, Zip: _____

Relationship of Client to Insured: _____ Employer of Insured:_____

Insurance Company:_____ Phone: _____

Insurance Company Address: _____ City, State, Zip:_____

Insurance Identification Number: _____ Group Number: _____

Secondary insurance: _____ Phone: _____

Name of Secondary Insured: _____ Insured Date of Birth:_____

Secondary Company Address: _____ City, State, Zip:_____

Secondary Identification Number: _____ Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____

Signature Date

FOR PROVIDER USE ONLY

DSM-5: DIAGNOSIS: ICD-10 DIAGNOSIS: