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CHILD AND ADOLESCENT INFORMATION SHEET

Date:_____

Name:_____ Age ____ Birthdate_____
Address: _____ Home Phone: _____
_____Social Security #: _____
Mother's Work Phone: _____ Father's Work Phone: _____
Mother's Cell Phone: _____ Father's Cell Phone: _____
School: _____ Grade: ___ Religion: _____

PARENTS AND/OR GUARDIAN

Father:_____ Age _____ Birthdate _____
Address: _____
Social Security #: _____Education _____
Marital Status: _____ Date Last Married: _____ Previous Marriages: _____
Occupation: _____Home Phone: _____

Mother: _____ Age_____ Birthdate_____
Address: _____
Social Security #: _____ Education _____
Marital Status: _____Date Last Married: _____ Previous Marriages: _____
Occupation: _____Home Phone: _____

STEP PARENTS

Name Address Social Security # Birthdate/Age

_____
_____
_____

BROTHERS AND SISTERS

Name Birthdate/Age Address Relationship Occupation

_____
_____
_____

Presenting Problem:_____
Who Referred you:_____ Family MD_____

INSURANCE INFORMATION:

Do you want this office to file insurance claims for you? YES NO
If "YES", complete this section. If "NO" skip this section.

Primary Insurance:_____
Policy Holder: _____
Relationship to Policy Holder: _____
Policy Holder's Date of Birth: _____
Policy ID#:_____ Group #:_____
Claims Address:_____
CoPay Amount:_____

Secondary Insurance:_____
Policy Holder: _____
Relationship to Policy Holder: _____
Policy Holder's Date of Birth: _____
Policy ID#: _____ Group #: _____
Claims Address: _____
Who is financially responsible for this bill? _____
Address of responsible person: _____
Will you be paying today by: Check ___ Cash ___ Credit Card ___

I agree to pay this account in accordance with the policy of the provider. I understand that if my account is overdue, there will be a 3% interest charge each 30 days that my portion of my account is overdue. In the event of default on my account, I agree to pay a collection and/or attorney fee.

Signed:_____ **Date:** _____

THANK YOU for completing this questionnaire. ***PLEASE*** let me know if any of the information changes.

CONSENT TO EVALUATE/ASSESS/TREAT A MINOR

Patient: _____
Address:_____
Date of Birth/Age:_____

I hereby authorize Lorrie G. Beevers, PhD. to evaluate, assess and/or treat my child/ward:

_____

Signature:_____(Parent or legal guardian) Date:_____
Witness:_____Date:_____