Psychological Associates of Warwick

PATIENT INFORMATION – CHILD

PLEASE PRINT CLEARLY DATE _____

NAME _____ AGE _____ GENDER IDENTITY _____

ADDRESS _____ CITY/STATE/ZIP _____

SOC. SEC. #_____ DOB _____ IS THIS CHILD ADOPTED? _____

SCHOOL NAME, LOCATION, AND GRADE _____

PARENT/GUARDIAN #1 INFORMATION:

NAME_____ DOB _____

ADDRESS _____ CITY/STATE/ZIP CODE _____

EMPLOYED BY _____ PHONE NUMBER _____

PARENT/GUARDIAN #2 INFORMATION:

NAME_____ DOB _____

ADDRESS _____ CITY/STATE/ZIP CODE _____

EMPLOYED BY _____ PHONE NUMBER _____

WHO LIVES IN THE CHILD'S HOME? _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____

Primary Insurance _____ Subscriber _____ SSN _____

Primary Insurance Policy Number _____

Secondary Insurance _____ Subscriber _____ SSN _____

Secondary Insurance Policy Number _____

REFERRED BY _____ NAME OF FAMILY DOCTOR/PCP_____

IS CHILD CURRENTLY BEING TREATED BY ANOTHER PHYSICIAN? _____

IF YES, WITH WHOM AND FOR WHAT REASON? _____

LIST ANY MEDICATIONS CHILD IS CURRENLTY TAKING

_____