WellSpring Child and Family Psychology, PC

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Patient Information Form (Child/Adolescent)

Patient Information:
Last Name:_____ Middle:_____ First:_____
Date of Birth:_____ Gender:_____
Parent/Guardian(s):_____
Parent(s)/Guardian(s) are: Married:____ Single:____Separated:___ Divorced:___
Custody Arrangement (sole/joint):_____

Contact Information:
(Note: If the child has multiple guardians who live separately, please list addresses and contact information for both/all)

Primary Address:_____
City:_____ State:_____ Zip Code:_____
Secondary Address:_____
City:_____ State:_____ Zip Code:_____
Cell Phone:_____ Ok to leave voicemail? yes ____ no____
Home Phone:_____ Ok to leave voicemail? yes ____ no____
Work Phone:_____ Ok to leave voicemail? yes ____ no____
Emergency Contact:_____ Relationship:_____ Phone:_____
(your provider may attempt to contact this person in case of emergency)

Insurance Information: (please initial one choice below)

___ I have in-network insurance. I will be responsible for copays/coinsurance, deductibles, and uncovered fees. I will contact insurance to ensure coverage.
___ I will use insurance, but since provider is out-of network, I will be responsible for paying in full for sessions and submitting claims myself.
___ I/My child does not have insurance and I would like to self-pay for sessions.

Insurance:_____ ID#:_____
Group #:_____ Effective Date:_____
Policy Holder Name:_____ Policy Holder DOB:_____
Policy Holder SSN:_____
Insurance Contact Number (for Mental Health/Providers):_____
Insurance Billing Address:_____
Is the patient covered by any other insurance coverage? yes____ no____

Other Information:
School Name:_____ Grade:_____
Teacher(s):_____
Primary Care/Pediatrician Name:_____ Practice Name:_____

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