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Child Patient Information Form

Child's Name: _____ Date of Birth: _____ Today's Date: _____

Gender: _____ Preferred Gender Pronouns (if applicable): _____

Age: _____ Race/Ethnicity: _____

Parent/Guardian Name 1 & Relationship: _____

Parent/Guardian Name 2 & Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number (home/work/cell): _____

Secondary Phone Number (home/work/cell): _____

Secondary Address (if different than primary): _____

Parent(s) Relationship Status: _____

Referring Provider: _____

Current Medications: _____

Previous Mental Health Services: _____

Presenting Problems: _____

CONTACT INFORMATION IN CASE OF EMERGENCY

Name: _____ Relationship to Child Patient: _____

Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Phone#: _____

Insurance Company Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Address (if different than above): _____ Phone #: _____

ID#: _____ Group#: _____

Name of Policy Holder's Employer : _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Phone#: _____

Insurance Company Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____

Address (if different than above): _____ Phone #: _____

ID#: _____ Group#: _____

Name of Policy Holder's Employer: _____