Candace Young, PhD - Child/Adolescent Intake Form

NAME OF PATIENT

WHO REFERRED YOU TO ME?

BIRTH DATE OF PATIENT SEX OF PATIENT M ☐ F ☐

HOME ADDRESS

CITY, STATE, ZIP CODE

E-MAIL ADDRESS SCHOOL GRADE IN SCHOOL

HOME PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐

CELL PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐

FATHER'S INFORMATION YOUR NAME

YOUR SSN YOUR BIRTH DATE

ADDRESS IF DIFFERENT

HOME PHONE IF DIFFERENT CELL PHONE

EMPLOYED BY WORK PHONE

MOTHER'S INFORMATION YOUR NAME

YOUR SSN YOUR BIRTH DATE

ADDRESS IF DIFFERENT

HOME PHONE IF DIFFERENT CELL PHONE

EMPLOYED BY WORK PHONE

NAME BIRTH DATE RELATIONSHIP TO PATIENT

WHO LIVES WITH PATIENT?

IF PARENTS ARE DIVORCED, WHO HAS CUSTODY OF PATIENT?

PRIMARY INSURANCE

INSURANCE CO NAME

STREET ADDRESS/PO BOX

CITY, STATE, ZIP CODE

INSURANCE CO PHONE

NAME OF POLICY HOLDER

ID# OF POLICY HOLDER

GROUP #

GROUP NAME

DATE OF BIRTH OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

SELF ___

SPOUSE ___

PARTNER___

CHILD ___

ADDRESS AND PHONE OF POLICY HOLDER (IF DIFFERENT)

STREET ADDRESS

CITY, STATE, ZIP CODE

HOME PHONE

WORK PHONE

CELL PHONE

SECONDARY INSURANCE

INSURANCE CO NAME

STREET ADDRESS/PO BOX

CITY, STATE, ZIP CODE

INSURANCE CO PHONE

NAME OF POLICY HOLDER

ID# OF POLICY HOLDER

GROUP #

GROUP NAME

DATE OF BIRTH OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

SELF ___

SPOUSE ___

PARTNER___

CHILD ___

ADDRESS AND PHONE OF POLICY HOLDER (IF DIFFERENT)

STREET ADDRESS

CITY, STATE, ZIP CODE

HOME PHONE

WORK PHONE

CELL PHONE

FOR OFFICE USE ONLY DX USUAL PROC CODE USUAL POS USUAL FEE

- I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided by Dr Young. This release of information expires December 31, 2015.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Young. I request payment of government benefits either to myself or to the party who accepts assignment.
- I understand that I am fully responsible for all professional fees not covered by this assignment.
- I understand that payment in full is due at the time of service unless prohibited by Dr Young's contract with my insurer.

Signature **Date**