

Date of Intake _____ Doctor _____

Client Information Form – Child/Minor

Client | Legal Name: _____ Preferred Name: _____
SSN: _____ Birth Date: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone No. (Home) _____ (Cell) _____
Custody held by: _____
School _____ Grade _____

Physician | Name: _____ Phone No: _____
Do you have a doctor's referral number for services at this practice? _____
If not, whom may we thank for referring you? _____

Mother | Name: _____ Date of Birth: _____
Address: _____
Employer: _____
Phone No. (Home) _____ (Work) _____ (Cell) _____
At which of these numbers can you most easily be reached? _____
At which number can we leave a brief message if necessary? _____
E-mail address _____

Father | Name: _____ Date of Birth: _____
Address: _____
Employer: _____
Phone No. (Home) _____ (Work) _____ (Cell) _____
At which of these numbers can you most easily be reached? _____
At which number can we leave a brief message if necessary? _____
E-mail _____

Billable Party | Name: _____ Relationship to Patient: _____
Address: _____
Phone No. (Home) _____ (Work) _____ (Cell) _____

Client _____

Insurance | Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's SSN: _____ Birth Date: _____
Please provide a copy of your insurance card.

Signature | Your signature below indicates that you have been provided with the following:

1. Alabama Notice Form (HIPAA)
2. Client Services Agreement
3. Fee Schedule

Signature of Guardian or Legal Representative

Date

Signature of Billable Party

Date