

BEHAVIOR MANAGEMENT SYSTEMS, INC.

CHILD/ADOLESCENT PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Gender: (circle) Male Female School: _____ Grade: _____
Address: _____ Soc. Sec. No.: _____
City: _____ State: _____ ZIP: _____ Telephone: _____

Mother's Name: _____ Biological – Step – Adoptive – Guardian (circle)
Mother's Soc. Sec. No.: _____ Date of Birth: _____ Telephone: () _____
Address: _____ City: _____ State: _____ ZIP: _____ Cell Phone: () _____
Mother's Employer: _____ Occupation: _____
Employer's Address: _____ Phone: () _____ Ext: _____
City: _____ State: _____ ZIP: _____

Father's Name: _____ Biological – Step – Adoptive – Guardian (circle)
Father's Soc. Sec. No.: _____ Date of Birth: _____ Telephone: () _____
Address: _____ City: _____ State: _____ ZIP: _____ Cell Phone: () _____
Father's Employer: _____ Occupation: _____
Employer's Address: _____ Phone: () _____ Ext: _____
City: _____ State: _____ ZIP: _____

Was the patient referred? Yes - No (circle) If yes, may we acknowledge your visit? Yes - No (Circle)

Referring person's name: _____
Referring person's address: _____
City: _____ State: _____ ZIP: _____

Should it become necessary to contact you regarding your child's appointment or other matters, what phone number will be best for us to call? _____ May we leave a message with your machine/voice mail or other person if you are not available? _____ Email Address: _____

I have been provided with access to the psychologist-patient agreement and consent for the treatment of my child/adolescent in compliance with the federal and state requirements of HIPAA. My signature is an acknowledgement of my consent for the treatment and how confidential information is to be handled between myself and my child/adolescent.

Signature of Parent/Responsible Party

Date