484-891-1226
grow@candokidstherapy.org

Patient Information

Name: ______________________________ Date: ________________

Date of Birth: __________________________ Parent Name: ________________

Sex: ☐ Male ☐ Female

Preferred phone contact:

☐ Home Phone: ____

☐ Work Phone: ____

☐ Cell Phone: ____

Address: ____

City: ____________________________ State: ________ Zip: __________

Social Security Number: ______________________________________

Parent's Occupation: ______________________________________

Parent's Employer: ______________________________________

School/Care Provider ______________________________________

Parent/Spouse's Employer: ______________________________________

Primary Care Physician's Name: ______________________________________

Primary Care Physician's Address: ______________________________________

City: ____________________________ State: ________ Zip: __________

Person Responsible for Payment: ______________________________________

Address (if different from patient address): ______________________________

Phone number (if different from patient phone): ____________________________

How did you hear about this practice?

☐ Doctor

☐ Friend/Family Member

☐ Self

☐ Other

Insurance Information

Please provide a copy of your insurance card if planning to submit for reimbursement.

☐ We are opting for self-pay only

Primary Insurance: ______________________________

Policy Holder Name: ______________________________

Group Number: ______________________________

Phone Number: ______________________________

Secondary Insurance: ______________________________

Policy Holder Name: ______________________________

Group Number: ______________________________

Phone Number: ______________________________

____

Name of Person Completing This Form

____

Relationship to Patient