❖ INTAKE FORM - CHILD OR ADOLESCENT ❖

CHILD'S NAME
GENDER MALE FEMALE DATE OF BIRTH

WHO REFERRED YOU TO ME?

HOME PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO
HOME ADDRESS
CITY, STATE, ZIP

WITH WHOM DOES THE CHILD LIVE?

WHO HAS CUSTODY OF THE CHILD?

RESPONSIBLE PARTY BRINGING CHILD TO TREATMENT
YOUR NAME YOUR RELATIONSHIP TO CHILD
YOUR SSN YOUR BIRTH DATE
YOUR ADDRESS IF DIFFERENT FROM CHILD
CITY, STATE, ZIP CODE
HOME PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO
CELL PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO
E-MAIL ADDRESS MAY WE E-MAIL YOU? YES NO
EMPLOYED BY OCCUPATION
WORK PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO

OTHER PARENT LIVING IN THE SAME HOUSEHOLD
YOUR NAME YOUR RELATIONSHIP TO CHILD
YOUR SSN YOUR BIRTH DATE
CELL PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO
E-MAIL ADDRESS MAY WE E-MAIL YOU? YES NO
EMPLOYED BY OCCUPATION
WORK PHONE MAY WE CALL? YES NO LEAVE A MESSAGE? YES NO

PRIMARY INSURANCE COMPANY NAME

ADDRESS/PO BOX
CITY STATE ZIP
INSURANCE PHONE
MENTAL HEALTH PHONE

POLICY HOLDER'S NAME
ID# CHILD'S RELATIONSHIP TO POLICY HOLDER
GROUP # SELF
GROUP NAME CHILD
POLICY HOLDER'S DATE OF BIRTH OTHER

IF POLICY HOLDER IS NOT LISTED ELSEWHERE, FILL OUT BELOW
SSN
EMPLOYER
STREET ADDRESS
CITY STATE ZIP
HOME PHONE
WORK PHONE
CELL PHONE

SECONDARY INSURANCE COMPANY NAME

ADDRESS/PO BOX
CITY STATE ZIP
INSURANCE PHONE
MENTAL HEALTH PHONE

POLICY HOLDER'S NAME
ID# CHILD'S RELATIONSHIP TO POLICY HOLDER
GROUP # SELF
GROUP NAME CHILD
POLICY HOLDER'S DATE OF BIRTH OTHER

IF POLICY HOLDER IS NOT LISTED ELSEWHERE, FILL OUT BELOW
SSN
EMPLOYER
STREET ADDRESS
CITY STATE ZIP
HOME PHONE
WORK PHONE
CELL PHONE

FOR OFFICE USE DX USUAL PROCEDURE CODE USUAL POS USUAL FEE

- I authorize the release of any medical or other information necessary to process insurance claims for services provided by Dr Johannsen This release of information expires December 31, 2014.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Johannsen 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 of insurance benefits.
- I understand that payment in full is due at the time of service unless prohibited by Dr Johannsen's contract with my insurer.

Responsible Party's Signature **Date**

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