Weston Psychological Associates

WELCOME TO OUR PRACTICE

Personal Information - Child

Today's date: _____Your appointment is with: _____

A. Identification (Child)

Name: _____

Sex:_____ Age:_____ Date of Birth:_____

Home street address: _____ Apt._____

City: _____ State: _____Zip: _____

Home phone:_____ Cell #(mom)_____Cell# (dad)_____

Teacher:_____School:_____GradeLevel:_____

B. Child's medical care: From whom or where does the child get medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If your child enters treatment with me, may I tell his/her medical doctor so that he or she can be fully informed and we can coordinate the treatment? □ Yes □ No

C. Marital status of biological parents □ married □ separated □ divorced □ remarried

D. Do you have legal authority to authorize medical or mental health treatment? □ yes □ No

E. If parents are divorced or separated, what is the custody and/or visitation arrangement? _____

_____

F. Living in Home (List all members of household):

Name:_____ Age:_____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship: _____

G. If parents are divorced or separated, who is living in other parents' home?

Name:_____ Age:_____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship: _____

H. Identification (Father or Guardian):

Your name: _____Date of birth: _____ Age: _____

Your E-mail address:_____ Social Security #:_____

May we use your e-mail to communicate with you? _____yes _____no

May we confirm your appointment via text message? ____yes _____no

Home street address: (if different from child):_____

City: _____State: _____Zip: _____ Home/evening phone: _____

I. Identification (Mother or Guardian):

Your name: _____Date of birth: _____ Age: _____

Your E-mail address:_____ Social Security #:_____

Home street address: (if different from child):_____

City: _____State: _____Zip: _____ Home/evening phone: _____

J. **Emergency Contact:**

Name: _____Relationship: _____

Phone: _____

K. Referred by

- South Florida Parenting
- Natural Awakenings
- Internet search
- Google
- EEG Info
- Insurance Carrier
- Other:_____

Name: _____ Phone: _____

Address: _____

_____

May I have your permission to thank this person for the referral? □ Yes □ No

L. Are you involved in a lawsuit or any legal proceedings? If yes, what is the nature of the suit?

_____

Name and phone # of Attorney: _____

M. I understand that I am responsible for all charges, regardless of insurance coverage._____Initials

N. Assignment of benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Weston psychological Associates. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original. _____Initials

O. I give this office permission to release any information obtained during examinations or treatment, to my Insurance company, to support any insurance claims on this account and secure timely payments due to the Assignee or myself.

_____ _____

Parent/Guardian's signature Date