

CAHABA PSYCHOLOGY CENTER
CHILD and ADOLESCENT INFORMATION FORM
TO BE COMPLETED BY PARENT or LEGAL GUARDIAN:

Today's Date: _____

Name and Relationship of Person Completing Form: _____

Child's Full Name: _____ SS# _____

Child is called: _____ Age: _____ Sex: Male Female

Date of Birth: ____/____/____ Present School: _____ Grade _____

Home Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____ Under whose name is this listing? _____

Cell Phone/ Beeper #: _____ Email Address _____

Brief Statement of Concerns: _____

How Did You Hear About Us? _____

Primary Care Physician: _____ Phone # _____

Child's Natural or Adopted Parents are: Living Together Separated Divorced

Father Deceased Mother Deceased Father Remarried Mother Remarried

Natural or Adopted Father's Full Name: _____

Address if different than above: _____

Natural or Adopted Mother's Full Name: _____

Address if different than above: _____

Stepfather's Full Name: _____

Address: _____

Stepmother's Full Name: _____

Address: _____

This Child Lives With: _____ Relationship to Child: _____

(If applicable, Child is in Legal Custody of: _____ Full Joint)

Family Employment

Name of Employed Person	Place of Employment	Type of Work
1) _____	_____	_____
2) _____	_____	_____

Father's Work Phone: _____ Mother's Work Phone: _____

Stepfather's Work Phone: _____ Stepmother's Work Phone: _____

Siblings:

Names	Age	Relationship	School, Grade
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____

In Case of Emergency Please Contact:

Name: _____ Phone #: (____) _____ Relationship to child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

Insured _____

Insured _____

DOB _____ Employer _____

DOB _____ Employer _____

Patient's Relationship to Insured:

Patient's Relationship to Insured:

Self Spouse Child Other

Self Spouse Child Other

Authorization Number _____

Authorization Number _____

of Visits _____ CoPay _____

of Visits _____ CoPay _____

Deductible \$\$ _____ SSN _____

Deductible \$\$ _____ SSN _____