NEUROBEHAVIORAL MEDICINE GROUP

OUTPATIENT INFORMATION
CHILD AND AOLESCENT 2

Patient Name _____Date of Birth _____

Address_____ City _____ Zip Code_____

Home Phone # _____ Cell #_____

Emergency Contact_____Cell #_____Other #_____

Relationship of Emergency Contact to Patient_____

Mother's Name_____ Cell #_____ Home #_____

Father's Name_____ Cell #_____ Home #_____

Marital Status of Parents_____

Legal Custody of Patient_____Physical Custody of Patient_____

Responsible Party for Payment_____

Address_____City_____Zip Code_____

Phone #_____Fax #_____Email Address_____

We are private pay but in the case of needing prior authorizations for medications, please provide the following insurance information:

Health Insurance and I.D. #_____

Prescription Insurance and I.D. #_____

Prescription Prior Authorization tel. #_____

Referred to this Office By_____
Reason for Referral_____

Current Medications and Prescribing Physician_____

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