

# NEUROBEHAVIORAL MEDICINE GROUP

## OUTPATIENT INFORMATION CHILD AND ADOLESCENT

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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