

**BRIAN S. TAYLOR, MD, JOYCE WECKL, PMHNP, FERNANDO CERVANTES, PMHNP**

**CHILD/ADOLESCENT PATIENT INFORMATION**

Please complete all fields and provide us with a copy of patient photo identification & insurance card(s) as applicable.

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_ RACE/ETHNICITY \_\_\_\_\_ SEX/IDENTIFIED AS: M F Other: \_\_\_\_\_

SS # \_\_\_\_\_ NAME YOU WOULD LIKE US TO CALL YOU? \_\_\_\_\_

**PARENT #1**

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIOLOGICAL \_\_\_\_\_ ADOPTIVE \_\_\_\_\_ STEP \_\_\_\_\_ OTHER \_\_\_\_\_

**PARENT #2**

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIOLOGICAL \_\_\_\_\_ ADOPTIVE \_\_\_\_\_ STEP \_\_\_\_\_ OTHER \_\_\_\_\_

**\*\*\*\* PLEASE CIRCLE ADDRESS & PHONE NUMBER FOR US TO CONTACT PARENT #1 OR PARENT #2 \*\*\*\***

**SOURCES OF INFORMATION:**

PERSON/S COMPLETING THIS FORM: RELATIONSHIP \_\_\_\_\_

**PATIENT'S LEGAL GUARDIAN(S):**

\_\_\_\_\_ MARRIED PARENTS

\_\_\_\_\_ UNMARRIED PARENTS

\_\_\_\_\_ SINGLE PARENT/SOLE CUSTODY

\_\_\_\_\_ DIVORCED PARENTS; JOINT CUSTODY AND DECISION MAKING

\_\_\_\_\_ DIVORCED PARENTS; SOLE CUSTODY OF \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_ OTHER:

IF APPLICABLE, DID YOU BRING THE PARENTING PLAN/CUSTODY DECREE? \_\_\_\_\_ YES \_\_\_\_\_ NO

PATIENT'S PRIMARY CARE PROVIDER: \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

FINANCIALLY RESPONSIBLE PARENT: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHARMACY LOCATION: \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE: \_\_\_\_\_ IS THIS YOUR PRIMARY INSURANCE?    YES        NO

INSURANCE ID # \_\_\_\_\_ GROUP OR PLAN# \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY HOLDERS SS # \_\_\_\_\_ DOB: \_\_\_\_\_

IS INSURANCE THROUGH EMPLOYER?    YES        NO                    INSURED'S EMPLOYER: \_\_\_\_\_

DO YOU HAVE A SECONDARY POLICY?    YES        NO                    NAME OF PLAN: \_\_\_\_\_

INSURANCE ID # \_\_\_\_\_ GROUP OR PLAN # \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ INSURED'S DOB: \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_ PHONE # \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. UPON A CHANGE IN MY INFORMATION, I WILL IMMEDIATELY PROVIDE UPDATES TO THIS OFFICE. I UNDERSTAND THAT ALTHOUGH I MY HAVE INSURANCE, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT FOR SERVICES DIRECTLY TO THIS OFFICE AND AGREE TO PAY THE DIFFERENCE. I AUTHORIZE DR. TAYLOR AND/OR JOYCE WECKL TO RELEASE ALL INFORMATION NECESSARY FOR MY INSURANCE TO PAY OR CONSIDER MY CLAIMS.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_