alo·ha psych ASSOCIATES, INC.

PATIENT REGISTRATION - MINOR

This intake information will be kept confidential, in your child's chart, and will not be released without your written consent or as required by law.

DATE CHILD'S NAME SOCIAL SECURITY # BIRTH DATE GENDER

MAILING ADDRESS CITY STATE ZIP CODE

HOME PHONE SCHOOL SCHOOL PHONE GRADE

COUNSELOR TEACHER ADDITIONAL SCHOOL INFORMATION

REFFERED BY: (CIRCLE ONE) SELF FAMILY MEMBER FRIEND PHYSICIAN SCHOOL COUNSELOR

LEGAL REFEERAL PASTOR/PRIEST PHONE BOOK PROVIDER DIRECTORY INTERNET OTHER

INSURANCE CARRIER ID NUMBER GROUP/POLICY NUMBER

SUBSCRIBER NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

FAMILY/GUARDIAN INFORMATION:

MOTHER'S NAME BIRTHDATE SOCIAL SECURITY PREFERRED PHONE NUMBER

MOTHER'S OCCUPATION WORK NUMBER PREFERRED E-MAIL EDUCATION

FATHER'S NAME BIRTHDATE SOCIAL SECURITY PREFERRED PHONE NUMBER

FATHER'S OCCUPATION WORK NUMBER PREFERRED E-MAIL EDUCATION

ADDRESS CITY STATE HOME PHONE NUMBER

EMERGENCY CONTACT 1 RELATIONSHIP TO CLIENT ADDRESS PHONE NUMBER

EMERGENCY CONTACT 2 RELATIONSHIP TO CLIENT ADDRESS PHONE NUMBER

- **My signature on this form authorizes contact with my Primary Care Provider.**
- **My signature on this form authorizes the release of medical information necessary to process this claim for my insurance.**
- **My signature on this form authorizes payment of insurance benefits to my treating provider and acknowledgment that co-payments are expected at the time of the visit.**

SIGNATURE **DATE**