# PSYCHOLOGICAL SERVICES OF PENDLETON, LLC
## GENERAL INFORMATION FOR MINORS / DEPENDANTS

**MINOR/ DEPENDANT**: _____ **Date of Birth:** _____/_____/_____
First Middle Last

**Address:** _____
Mailing Address City State Zip Code

**Social Security #:** _____-_____-_____ **Gender**: Male ☐ or Female ☐ **Age:** _____ **School Grade?**_____

**Proof of Custodial Parent: Copy taken for chart?**_____

**PARENT/ GUARDIAN**: _____
First Last Middle Initial

**Date of Birth**: _____/_____/_____ **Social Security #:** _____-_____-_____ **Gender**: Male ☐ or Female ☐

**Address:** _____
Mailing Address City State Zip Code

**Home #**:_____ **Work #**:_____ **Cell #**:_____

***May we contact you at the above numbers and leave messages*?** **Home** ☐ **Work** ☐ **Cell** ☐

Email Address:_____

*May we contact you by email ? yes no*

_____ _____
**Parent/ Guardian's Employer** **Phone Number**

_____ _____
**Minor/ Dependant's Primary Doctor or Care Provider's Name** **Phone Number**

_____ _____
**Pharmacy Name and City** **Phone Number**

_____ _____
**Primary Insurance** **Subscribers Name/Relationship** **Subscribers DOB**

**Subscriber's address if different from patient:** _____

_____ _____ _____
**Policy Number** **Group Number** **Employer**

_____ _____
**Secondary Insurance** **Subscribers Name/Relationship** **Subscribers DOB**

**Subscriber's address if different from patient:** _____

_____ _____ _____
**Policy Number** **Group Number** **Employer**

**My signature on this form authorizes contact with my dependant's doctor or primary care provider. My signature on this form authorizes the release of medical information necessary to process claims for my insurance company. My signature on this form authorizes payment of insurance benefits to the treating provider. Sending claims to my insurance company is a service provided by Psychological Services of Pendleton, LLC. By signing this form, I certify that I am legally responsible for any charges incurred for my dependant to this provider.**

_____
**SIGNATURE of Patient** **DATE**

_____
**SIGNATURE of Parent/Guardian** **DATE**

**REMINDER: YOUR CO-PAY/CO-INSURANCE IS DUE AT THE TIME OF EACH VISIT**