

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 ☐

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

Claims Address

Subscribers Name/Relationship

Subscriber's address if different from patient: _____

Policy Number

Group Number

Employer

Secondary Insurance

Claims Address

Subscribers Name/Relationship

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