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