MODIFY

Child Background History

As we begin our working relationship, I would like to ask you to fill out the following form. To protect your confidentiality, none of this information will be disclosed and nobody will be contacted without your written permission.

Child's Name: _____

Parents' Name: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

May we leave a voice message? ____Yes ____No If needed please specify_____

Email (list only if you are comfortable to receive occasional email messages)

_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Child's Gender: _____Male _____Female Age: _____ Date of Birth of Child: _____

Emergency Contact: _____

Address: _____

Phone: _____ Relationship: _____

In the last year has your Child had a physical exam? _____ Yes _____ No.

Who referred you to our agency? _____

Please list the Name, Address and Telephone number of your Primary Care

Physican_____

_____

Primary Insurance: _____ ID#: _____ Group#: _____

Insured's Gender: _____Male _____Female. Date of Birth (insured) _____

Secondary Insurance: _____ ID#: _____ Group#: _____