Child Demographic Information

Welcome to Modify, 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.

Patient Name: ___________________________________ *Preferred Name:*______________ *Date:*________________

Address: ____*City:*___________________ *Zip Code:*___________

Parents' Name: _____________________________________ *Phone:*______________________ *Home - Work - Cell*

May we leave a text message? ______*Yes* ______ *No, May we leave a voice message?* ______*Yes* ______*No*

Parents' Email: ____

Patient Birthdate: _____ /_____ / _____ *Age:* _______ *Gender:* ________ *Gender Identity:*__________________

*Sexual Orientation:*_____________________ *Ethnicity:*___________________ *Religion:*_______________________

Emergency Contact: ___________________________ *Phone:*___________________ *Relationship:*________________

How did you hear about us? ____

Insurance:

Insured's Gender: ______ *Date of Birth (insured):* _____ / _____ / _____

Name of Insured: ____ *Employer:* ___________________________

Primary Insurance: _________________________ *ID #:* _________________________ *Group #:* ________________

Secondary Insurance: _______________________ *ID#:* __________________________ *Group #:* ________________

Care Team:

Primary Care Physician: ____ *Phone:*_____________________________

Date of last physical exam: ____________________

*Psychiatrist or other mental health professional:*______________________________ *Phone:*___________________

Education:

Current Student: ____*Yes, School name:*_______________________________________ *Grade:*________________

Current Student: ____ No, Highest level of education achieved:____

Does your child have any resources being utilized in their school? (504plan, IEP, etc.) _________________________

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