



Face Sheet

CLIENT INFORMATION

DATE: _____

Name: _____

Sex (circle one): M or F

Birth date: _____ Age: _____

PARENT/GUARDIAN INFORMATION (responsible party)

Name: _____

Relationship: _____

Address(es): _____

Phone: _____

E-mail: _____

Preferred method of contact (circle): Call Text E-mail Either

Best time(s) to contact: _____

INSURANCE PROVIDER/PLAN INFORMATION (check all that apply):

- No Insurance/Private Pay Please provide copy of Insurance Card

| | Primary | Secondary |
|-----------------------------------|---------|-----------|
| Name of Plan Provider | | |
| Policy Holders: Name, DOB, SS# | | |
| Policy/ID # | | |
| Group # (if applicable) | | |
| Phone #: Provider Services | | |

Please List Child's Current Physician and Practice:

Please check here if you authorize our clinic to contact your physician/practice to request updated prescriptions/referrals. If you do not check, you will be responsible for requesting this information.

Medication Changes/Allergies: (please update as needed): _____
