JOYCE E. WECKL, PMHNP

CHILD/ADOLESCENT PATIENT INFORMATION

Please complete all fields and provide us with a copy of patient photo identification & insurance card(s) as applicable.

LAST NAME:_____FIRST:_____MI: _____

DOB:_____RACE/ETHNICITY_____SEX/IDENTIFIED AS: M F Other: _____

SS # _____ NAME YOU WOULD LIKE US TO CALL YOU?_____

PARENT #1

NAME:_____

HOME ADDRESS:_____CITY:_____

STATE:_____ZIP CODE:_____EMAIL:_____

HOME PHONE:_____ CELL PHONE:_____

RELATIONSHIP TO PATIENT:_____ BIOLOGICAL _____ADOPTIVE_____ STEP_____ OTHER_____

PARENT #2

NAME:_____

HOME ADDRESS: _____ CITY: _____

STATE: _____ZIP CODE: _____EMAIL:_____

HOME PHONE:_____ CELL PHONE:_____

RELATIONSHIP TO PATIENT:_____ BIOLOGICAL _____ADOPTIVE_____ STEP_____ OTHER_____

****** PLEASE CIRCLE ADDRESS & PHONE NUMBER FOR US TO CONTACT PARENT #1 OR PARENT #2 ******

SOURCES OF INFORMATION:

PERSON/S COMPLETING THIS FORM: RELATIONSHIP_____

PATIENT'S LEGAL GUARDIAN(S):

_____ MARRIED PARENTS _____ UNMARRIED PARENTS

_____ SINGLE PARENT/SOLE CUSTODY _____ DIVORCED PARENTS; JOINT CUSTODY AND DECISION MAKING

_____ DIVORCED PARENTS; SOLE CUSTODY OF _____MOTHER_____FATHER _____ OTHER:

IF APPLICABLE, DID YOU BRING THE PARENTING PLAN/CUSTODY DECREE? _____ YES _____ NO

PATIENT'S PRIMARY CARE PROVIDER: _____HOW DID YOU HEAR ABOUT US?_____

FINANCIALLY RESPONSIBLE PARENT: _____

PHARMACY NAME:_____ PHARMACY LOCATION:_____

INSURANCE INFORMATION

INSURANCE: _____IS THIS YOUR PRIMARY INSURANCE? YES NO

INSURANCE ID # _____ GROUP OR PLAN#_____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDERS SS # _____ DOB: _____

IS INSURANCE THROUGH EMPLOYER? YES NO INSURED'S EMPLOYER: _____

DO YOU HAVE A SECONDARY POLICY? YES NO NAME OF PLAN: _____

INSURANCE ID # _____ GROUP OR PLAN # _____
INSURED'S NAME: _____ INSURED'S DOB:_____

IN CASE OF EMERGENCY NOTIFY_____ PHONE # _____

RELATIONSHIP TO PATIENT: _____

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. UPON A CHANGE IN MY INFORMATION, I WILL IMMEDIATELY PROVIDE UPDATES TO THIS OFFICE. I UNDERSTAND THAT ALTHOUGH I MY HAVE INSURANCE, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT FOR SERVICES DIRECTLY TO THIS OFFICE AND AGREE TO PAY THE DIFFERENCE. I AUTHORIZE DR. TAYLOR AND/OR JOYCE WECKL TO RELEASE ALL INFORMATION NECESSARY FOR MY INSURANCE TO PAY OR CONSIDER MY CLAIMS.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____