Delta Psychology Center

Dr._____
Date:_____
Time:_____
Office:_____

Child/Adolescent New Patient Information

Child's Name:_____Date:_____
DOB:_____Age:____Person calling:_____Relationship:_____
Home #: (____)_____Work #: (____)_____Cell#:(___)_____
May we call you at: Home?_____ Work?_____ Cell?_____ (check one or all)
Would you like to be on our mailing list? Y_____ N_____
Has your child ever been a patient here before?_____ If yes, Dr._____
Family Doctor:_____How did you hear about us?_____

With what problem does your child assistance?

_____

_____

_____

Child lives with: Name(s):_____Relationship:_____
Address:_____
Street City State Zip
Employed by:_____ Shift:_____
Occupation:_____ Soc. Sec.#s:_____

If applicable:
Other parents'name(s):_____Relationship:_____
Address:_____
Street City State Zip
Employed by:_____ Shift:_____
Occupation:_____ Soc. Sec.#s:_____

I understand the rights and responsibilities of this treatment, as well as the privileges and limits of limits of confidentiality. I hereby give permission to Delta Psychology Center for my evaluation and treatment.

Signature:_____ Date:_____

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