CAPA | CHILD & ADOLESCENT PSYCHOLOGY ASSOCIATES

Patient Registration Form

Patient information Patient age: _____

Patient Name: _____ Birthdate: _____

Patient Preferred Name: _____

Address: _____City: _____

State_____ Zip code: _____ County: _____

Gender: _____ Patient's School: _____

Patient phone number: _____ cell home (circle one)

Patient email: _____

Primary Care Physician: _____Physician Phone #_____

Referral Source: (circle one) Physician School Insurance Company Self/Internet search

Friend Other: _____

Family Information

Parent Name: _____ Phone Number: _____

Address (if different): _____

City: _____ State_____ Zip code: _____

Parent email: _____Parent Occupation: _____

Parent 2 Name: _____ Phone Number: _____

Address (if different): _____

City: _____ State_____ Zip code: _____

Parent email: _____Parent Occupation: _____

Parent marital Status: (circle one) Married Separated/Divorced Never Married Other

Please list the names and ages of other people living in the home: _____

_____

_____

Reason for Appointment

Please check the primary reasons for this appointment:

_____ Academic or learning struggles
_____ Anger, aggression or tantrums
_____ Mood/depression concerns
_____ Anxiety, fear or worry
_____ Social Difficulties
_____ Coping with physical pain/illness
_____ Sensory processing concerns
_____ Speech/Articulation struggles
_____ Defiance or oppositional behavior
_____ Attention, focus or memory problems
_____ Hyperactivity, overly talkative or impulsive
_____ Grief/loss
_____ Stress Management
_____ Adherence to medical needs
_____ Fine motor and/or coordination
_____ Language/Communication struggles

Other: _____

Insurance Information ____ Not applicable Self-Pay

Primary Insurance Carrier: _____

Policy ID #: _____ Group ID #: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to patient: _____ Policy Holder's SSN: _____

Address (if different from patient): _____

Policy Holder's phone number: _____

Employer: _____