Ponderosa Counseling

Child/Adolescent Registration Form

PATIENT INFORMATION

Patient's Name: Last:_____, First_____ MI_____

Date of Birth:_____ Phone: _____ (cell/home) Email:_____

Address:_____

City:_____ State:_____, Zip Code:_____

MOTHER/PARENT/GUARDIAN INFORMATION

Name: Last:_____, First: _____ Date of Birth: _____

Phone 1: _____ (cell/home/work) Phone 2: _____(cell/home/work)

Address:_____

City:_____ State:_____, Zip Code:_____

Email: _____ Employer: _____

FATHER/PARENT/GUARDIAN INFORMATION

Name: Last:_____, First: _____ Date of Birth: _____

Phone 1: _____ (cell/home/work) Phone 2: _____(cell/home/work)

Address:_____

City:_____ State:_____, Zip Code:_____

Email: _____ Employer: _____

PARENTS: Married_____ Divorced _____ Medical Decision Making: _____

Stepparents: _____

Siblings/Ages: _____

INSURANCE (optional) :_____ ID#:_____

Group#:_____ Prescription Plan:_____

Preferred Pharmacy:_____

PRIMARY CARE PHYSICIAN

Doctor's Name: _____Phone: _____

Practice Name: _____

REFERRAL SOURCE: _____