Cedar Tree Counseling

PERSONAL HISTORY (MINOR)

PATIENT

Patient Last Name:	First Name (legal):	Middle Name:	Nickname:
Address:	City:	State:	Zip:	Home/Cell Phone:
Age:	Date of Birth:	Sex: ☐ M ☐ F	SS# (required):

SIBLINGS

Sibling Name (last):	First:	M.I.	DOB:	☐ Male ☐ Female
Sibling Name (last):	First:	M.I.	DOB:	☐ Male ☐ Female
Sibling Name (last):	First:	M.I.	DOB:	☐ Male ☐ Female
Sibling Name (last):	First:	M.I.	DOB:	☐ Male ☐ Female

RESPONSIBLE PARTY

Father

☐ FATHER	☐ STEP-FATHER	☐ GUARDIAN	☐ FOSTER
Name (last):	First:	M.I.	DOB:	SS#:
Home/Mailing Address:	City:	State:	Zip Code:	Home Phone:
Home Email:				
Employer:	Occupation:	Work Email		Work Phone:
Employer Address:	City:	State:	Zip Code:	Cell phone:

Mother

☐ MOTHER	☐ STEP-MOTHER	☐ GUARDIAN	☐ FOSTER
Name (last):	First:	M.I.	DOB:	SS#:
Home/Mailing Address:	City:	State:	Zip Code:	Home Phone:
Home Email:				
Employer:	Occupation:	Work Email	Work Phone:	
Employer Address:	City:	State:	Zip Code:	Cell phone:

IN CASE OF EMERGENCY				
Name of Relative or Authorized Person to Notify in Case of Emergency:			Relationship:	Home Phone:
Street Address:	City:	State:	Zip Code:	Work Phone:

Child's Primary Care Physician: _____

Who referred you to our practice: _____

Please provide a current insurance card for the receptionist.

All copays are due at time of service.

I realize I am responsible for all monies not paid by insurance.

I also realize that if I am turned over to a collection agency to obtain payment for services rendered, I will be responsible for legal collection fees. We will not be involved in legal disputes.

_____ _____ _____

Signature Relationship Date