Rochester Psychological Associates
620 Crosskeys Office Park
Fairport, NY 14450

PATIENT INFORMATION (Child)

Patient Name_____ Date _____

Street Address_____ City, State _____ Zip_____

Birthdate_____ Parent's Marital Status_____

Phone(home)_____ (work)_____ (cell)_____

Father's name_____ Phone_____

Mother's name_____ Phone _____

Parents address (if different)_____

If divorced, parent(s) with legal custody_____(please show proof)

Patient's primary insurance_____ Contract #_____

Insured's name_____ Insured's relationship to patient _____

Insured's address_____ Insured's employer_____

Other Insurance_____

Who referred you to us?_____ Address_____

If not referred, how did you find this office?_____

Primary care physician_____

Address_____ Phone _____

Sign here if we have permission to exchange relevant clinical information* with this

physician (an HMO requirement) _____

Sign here to give permission to exchange relevant clinical information* with the referring

person if other than the PCP_____

***(Treatment summaries, progress reports, and phone contact as needed)**