

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)**