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**Patient Information**

Child's Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street Name Apt. #  
\_\_\_\_\_  
City State ZIP

Child's Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Mother's Hm Ph#: \_\_\_\_\_ Father's Home Phone: \_\_\_\_\_  
Mother's Cell #: \_\_\_\_\_ Father's Cell #: \_\_\_\_\_  
Mother's Email: \_\_\_\_\_ Email: \_\_\_\_\_

Child's Medicaid#: \_\_\_\_\_ Child SS#: \_\_\_\_\_  
H/C Physician: \_\_\_\_\_ H/C #: \_\_\_\_\_  
H/C Facility: \_\_\_\_\_ H/C Ph #: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax#: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ Plcy#: \_\_\_\_\_  
Plcy Holder Name: \_\_\_\_\_ Plcy Holder SS#: \_\_\_\_\_  
Plcy Holder DOB: \_\_\_\_\_

School: \_\_\_\_\_ School's Ph#: \_\_\_\_\_  
Address: \_\_\_\_\_ School's Fax#: \_\_\_\_\_  
Child's Grade: \_\_\_\_\_

Gen. Ed Teacher: \_\_\_\_\_  
SPED Teacher: \_\_\_\_\_ Does Child have an IEP/504 plan?  Yes  No

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Home Ph #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Ph #: \_\_\_\_\_

**Medical Information**

Allergies:  Yes  No

If "Yes" explain: \_\_\_\_\_  
\_\_\_\_\_

Medical Limitations:  Yes  No

If "Yes" explain: \_\_\_\_\_  
\_\_\_\_\_

List Medications	Dosage	Known Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Diagnostic History  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**General Information**

How did you find out about Pediatric Neuropsychology at Access Point?  
\_\_\_\_\_  
\_\_\_\_\_

What are your main concerns regarding your child's development / behavior?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child been evaluated (e.g., psychological, Neuropsychological, school, or educational testing such as an IQ test or academic tests) within the last 24 months?  No  Yes

Is your child under the care of a specialist (e.g., Neurologist, Psychiatrist, Oncologist, etc.)?  No  Yes

If "yes", please provide the following:  
Name of Providers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any brain imaging (CT Scans, MRI), an EEG, or a sleep study:  No  Yes

If "yes", please provide the following:  
Name of Providers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child currently receive any kind of therapy services, such as PSR, IBI, Speech Therapy, Occupational Therapy, Developmental Therapy or Counseling?

No     Yes

If "yes", please provide the following:

Name of Providers:

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**Payment Responsibility Statement**

***Patients and or patient's family are responsible for costs of services incurred that are not covered or is denied by 3<sup>rd</sup> party insurers, Medicaid, or other payment entities***

\_\_\_\_\_  
Responsible Parties Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

