BUSINSESS OFFICE INTAKE- CHILD

Child's Information **THERAPIST:** _____ **DATE**_____

Name_____ Date of Birth_____ Gender_____ Social Security #_____

Address:_____ City, State, Zip _____

Home Phone _____ Cell Phone_____ Preferred Phone # for calls and messages _____

With Whom does the Child Primarily Reside?_____

Emergency Contact_____ Relationship to Child_____

Mother's Information: Biological____ Adoptive____ Step Parent____ Guardian____

Name_____ Date of Birth_____ Social Security #_____

Address:_____ City, State, Zip _____

Home Phone _____ Cell Phone_____ Preferred Phone # for calls and messages _____

Marital Status: Single____ Married____ Divorced____ Separated____ Remarried____

Employed?____ Employer_____ Phone #_____ Ok to Call?____

Ok to communicate by email?____ Email Address:_____

Father's Information: Biological____ Adoptive____ Step Parent____ Guardian____

Name_____ Date of Birth_____ Social Security #_____

Address:_____ City, State, Zip _____

Home Phone _____ Cell Phone_____ Preferred Phone # for calls and messages _____

Marital Status: Single____ Married____ Divorced____ Separated____ Remarried____

Employed?____ Employer_____ Phone #_____ Ok to Call?____

Ok to communicate by email?____ Email Address:_____

Insurance information- Child

Insurance Name_____ Phone #_____

Policyholder's Name_____ Date of Birth_____ Relationship to Child _____

Insurance ID #_____ Group #_____ Employer_____

Is Child covered under any other policy? _____ If yes, provide secondary insurance information below. Note: If the secondary policy is Missouri Medicaid, any copays from primary insurances will be due from the Responsible Party for the child. We will not bill copays to Missouri Medicaid.

Secondary Insurance - Child

Insurance Name_____ Phone #_____

Policyholder's Name_____ Date of Birth_____ Relationship to Child _____

Insurance ID #_____ Group #_____ Employer_____

Insurance information for Responsible Party (if Person attending Therapy sessions with child is covered under a different policy, please complete)

Insurance Name_____ Phone #_____

Policyholder's Name_____ Date of Birth_____ Relationship to Child _____

Insurance ID #_____ Group #_____ Employer_____

Note: Insurance companies routinely check for other coverage on children and spouses. This is known as coordination of benefits (COB). If you receive a COB questionnaire, please respond promptly as your insurance can deny all claims until a response is given. Claims denied for COB information will be the responsibility of the person presenting the child for treatment.