Psychological and Substance Abuse Services, INC

21250 Box Springs Rd. Ste. 203 Moreno Valley, CA 92557 951.335.5858 Fax 951.335.5870

CHILDS INFORMATION

First Name _____ Last Name _____

Birth Date _____/_____/_____ Sex _____ Age _____ School Name _____ Grade _____

PARENT/GUARDIAN INFORMATION

First Name _____ Last Name _____

Date of Birth _____/_____/_____ Sex _____ DL No_____

Social Security Number_____/_____/_____ Email _____

Address _____ City _____State _____ Zip code _____

Home Phone _____ Cell Phone _____

Email Address _____

Other Parent Name _____ Phone No _____

REFERRAL SOURCE

Name _____ □ PCP □ Insurance □ Self □ Other _____

EMERGENCY CONTACT (other than parent/s)

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION

Insurance _____ Policy No _____
□ HMO □ PPO □ EPO □ Medi-cal □ Medicare

Group No _____ Employer Name _____

Subscriber Name _____ Subscriber DOB _____/_____/_____

Secondary Coverage _____ Policy No _____
□ Supplement □ Medi-cal □ Medicare □ HMO □ PPO □ EPO

I authorize to release my diagnosis and treatment information to my insurance company for the purpose of processing claims, benefits and payments for the services rendered to me □ Yes □ No

I understand that I am financially responsible for any amount not covered by my insurance company and am responsible to provide accurate insurance information □ Yes □ No

COORDINATION OF CARE

Primary Care Doctor _____Phone _____
Therapist _____ Phone _____
Psychiatrist _____ Phone _____
Treatment Center _____ Phone _____

I agree to release my diagnosis and treatment recommendation information to my providers listed above for coordination of care □ Yes □ No

HEALTH CONCERNS/SYMPTOMS

Describe your main concern (symptoms, onset, diagnosis, duration, etc.)
_____
_____

Purpose for testing:
_____
_____

Did you bring any medical records for review? □ Yes □ No

Please select all that apply:
□ TBI (Head injury) □ Stroke □ Brain Infection □ Brain Tumor □ Parkinson's disease □ Seizures □ Loss of Consciousness □ Diabetes □ Memory loss □ Neurological disorder □ Thyroid disease □ Chronic Pain □ Hypertension □ Liver disease □ Suffocation/drowning □ Headaches □ Cancer □ Obesity □ other _____

Is the child taking any medications? □ Yes □ No
Please list all the medications:
_____
_____

ALTERNATIVE COMMUNICATION

I wish to be contacted in the following manner (Check all that apply)
□ Home Phone _____ □ Cell Phone _____
Okay to leave message with details □ Yes □ No
□ Written Communication address _____

X_____ _____
Parent or Representative Signature Date