LINDEMAN & ASSOCIATES
Psychological Services

CHILD CLIENT INFORMATION

Please Print Clearly
THIS SHEET MUST BE FILLED IN COMPLETELY

Date:_____

Child's First Name:_____Last Name:_____MI

Address:_____City:_____

State:_____Zip:_____

Telephone (Home):_____(Work):_____(Cell):_____

Permission to leave a message at home? Yes_____No_____

Email address:_____

Birthdate:_____/_____/_____Age: _____ Biological Sex: M_____F_____

Gender Identity: M_____F_____Pronouns:_____

Mother's First Name:_____Last Name:_____

Place of Employment:_____Occupation:_____

Years of Schooling:____Work Phone:_____Permission to call you at work? Y_____N_____

Father's First Name:_____Last Name:_____

Place of Employment:_____Occupation:_____

Years of Schooling:____Work Phone:_____Permission to call you at work? Y_____N_____

Child's legal guardian (if not parents):_____

Legal Guardian's Address:_____

Child lives with: Mother & Father_Mother Father_Step-Parent _____

Other _____

If parents are divorced, is there joint LEGAL custody? Y____N____

Please list all others who live in the household and their ages:

Name Age Name Age

_____

_____

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Person Responsible for Payment:_____

Signature of Person Responsible for Payment:_____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1):_____Relationship:_____Phone:_____

Address:_____City:_____State:_Zip Code:_____

Name (2):_____Relationship:_____Phone:_____

Address:_____City:_____State:___Zip Code:_____

Physician:_____Phone:_____

Address:_____City:_____State:_____Zip Code:_____

Psychiatrist:_____Phone:_____

Address:_____City:_____State:_____Zip Code:_____

Other Treating Physicians:_____Phone:_____

_____Phone:_____

Current Medications:_____

Allergies:_____

PRIMARY INSURANCE:

Patient relationship to insured: Self_____Spouse_____Child_____Other_____

Insured's Name:_____Employer:_____

Insured's Address:_____

Insurance Co/Plan:_____

Insured's DOB:_____Insured's ID #:_____

Insured's SSN:_____Insured's Group/Policy #:_____

SECONDARY INSURANCE:

Patient relationship to insured: Self_____Spouse_____Child_____Other_____

Insured's Name:_____Employer:_____

LINDEMAN & ASSOCIATES
Psychological Services

Insured's Address: _____

Insurance Co/Plan: _____

Insured's DOB: _____ Insured's ID #: _____

Insured's SSN: _____ Insured's Group/Policy #: _____

**** Please note: If you do not provide our office with accurate insurance information at the time of service, payment for these services will be your responsibility. Please make sure to list ALL accurate insurance information. My signature below indicates that I understand and agree with all of these statements. I certify that all information is true, accurate and complete. I agree to be personally responsible for all charges not covered by my insurance.**

Signature of Client Or Legal Guardian: _____ Date: _____

Signature of Therapist: _____ Date: _____

Signature of Psychologist: _____ Date: _____