

Amend Psychological Services, PSC
CHILD REGISTRATION FORM

(Please Print)

Today's Date:	Psychologist: Dr. Edward R. Amend or Dr. Debra B. Huss
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CLIENT INFORMATION

Child's Legal Name Last:		First:	Middle:	Nickname:	
Grade:	School:	School District:		Date of Birth:	Age: Sex:
				/ /	<input type="checkbox"/> M <input type="checkbox"/> F
Address:		City:		State:	ZIP Code:
Primary Parent/Guardian Name (include <i>Last</i> if different):		Relationship to Child:		Cell Phone:	
		Home Phone:		Work Phone:	
Occupation:		Employer & Address:			
E-mail:					
Parent/Guardian Name (if applicable):		Relationship to Child:		Cell Phone:	
		Home Phone:		Work Phone:	
Home Address (if different from child's):		City:		State:	ZIP Code:
Occupation:		Employer & Address:			
E-mail:					
How did you find us? (please check box):		<input type="checkbox"/> Dr.	<input type="checkbox"/> Family	<input type="checkbox"/> Friend:	<input type="checkbox"/> Internet
<input type="checkbox"/> School:	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other family members seen here:		
<input type="checkbox"/> Other:					

BILLING INFORMATION

Person responsible for account:		<input type="checkbox"/> Parent (skip to Home History)	<input type="checkbox"/> Other (Name & Relationship to Child):
Address (if different):		Home Phone:	Cell Phone:
			Work Phone:
2nd Person responsible for account:		<input type="checkbox"/> Parent (skip to Home History)	<input type="checkbox"/> Other (Name & Relationship to Child):
Address (if different):		Home Phone:	Cell Phone:
			Work Phone:

HOME HISTORY

Please indicate other individuals in the household and their relationship to the Child:

Name & Age	Relationship	Level of Education	Occupation	Work Schedule

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address):	Relationship to Child:	Home Phone:	Cell Phone:	Work Phone:
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The above information is true to the best of my knowledge. I understand that I am financially responsible for any costs incurred from services provided, including any significant telephone and email correspondence with licensed associates of Amend Psychological Services, PSC. I also acknowledge that Amend Psychological Services, PSC has provided me with a copy of my rights to privacy through HIPAA and I have read and understand this information.

 Parent or Guardian Signature (if client is a minor)

 Date