Developmental Pediatric Specialists

PROMOTING CHILD DEVELOPMENT AND SUCCESS

Client Information

Patient Information:

Date: _______________ **Social Security Number:** __________________________

Name: ____
(Last) (First) (Middle)

Birthdate: ______________________ **Sex:** Male Female **Race:**_______

Address: ____ **Apt#:**_______
(Street)

City: ______________**State:** ______**Zip Code:** _________**County:**________________

Phone #: **Home:** (_____)_________________ **Best time to call:** _________
Work: (_____)_________________ **OK to leave voice message?**
Cellular: (_____)_________________ **Yes** **No**
May we contact you via email?
Email Address: _________________________________ **Yes** **No**

Insurance Information

**** Please note. Though our practice does not file any claims to insurance on your behalf, it is necessary to have this information available in the event we need to contact your insurance regarding GAP Exceptions, Prior Authorization, etc.****

Insurance Name: __________________ **Member ID #:**__________ **Group#:**__________

Subscriber Name: _________________ **Provider Services Number:** ____________________

Medical Information:

Primary Care Physician: ____

Address: ____ **Phone:** ________________

____

750 HAMMOND DRIVE BUILIDING 1 SUITE 100 ATLANTA, GA 30328
T. 404-303-7247 F. 404-303-7837

www.dpsatlanta.org

Release of Information:

Please note: The person with legal custody must sign the permission to evaluate below. If you have temporary custody, please bring all related paperwork with you to the appointment. If patient is 18 years or older, patient must sign below.

Authorization for Assessment/Therapy Treatment:

Developmental Pediatric Specialists, Inc. is authorized to initiate Evaluative/Diagnostic/Therapy procedures on the above-named patient to clarify issues pertinent to the health, development, or adjustment of the patient.

______________________________ ______________

Patient/Parent/Guardian Signature **Date**

Parent(s)/Legal Guardian(s):

Name: ______________________________
(Last) (First) (Middle)

Address: ______________________________
(Street) (Apt. #)

____
(City) (State) (Zip)

Relationship: ______________ Phone: ( ) ______________

Name: ______________________________
(Last) (First) (Middle)

Address: ______________________________
(Street) (Apt. #)

____
(City) (State) (Zip)

Relationship: ______________ Phone: ( ) ______________

ADDITIONAL INFORMATION

Emergency Contact Information (if we are unable to reach you):

____

Name | Relationship | Phone number

____

Parent/Guardian Signature **Date**

Additionally, the following person(s) have permission to transport the patient and to provide information in my absence:

Name:______________________ Relationship:____________

Name:______________________ Relationship:____________

Name:______________________ Relationship:____________

Adoption

If you child was adopted please circle the appropriate response:

1) The adoption can be discussed freely in front of the child YES NO

2) Please only discuss the adoption when the child is **NOT** present YES NO

If you circled YES to question two, please answer the following questions:

1) How old was your child at the time of adoption? ________
2) What country was your child adopted from? ____________________
3) Do you have any birth records or information about the birth family? YES NO
4) Did you have an open adoption? YES NO
5) If yes, are you still in contact with the birth parents? YES NO