

Behavioral Pediatrics Program
 1445 Portland Ave. #204
 Rochester, NY 14621
 (585) 922-4698 **Phone**
 (585) 922-5702 **Fax**

Intake Form

Date:

Childs' Name:		Mother's Full Name:	
Date of Birth		Father's Full Name:	
Age:			
Child's Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Separated <input type="checkbox"/> Never Married
Home Phone #:		Insurance Name:	
Mo. Work #		Subscriber #	
Mo. Cell#		Contract Holder:	
Fa. Work #		Employer:	
Fa: Cell #		Address and phone #	
	Indicate preferred # to call	Of insurance company:	
Primary Care MD:			
		Secondary Insurance:	
Mom's Home Address:		Subscriber #:	
		Contract Holder:	
Dad's Home Address:		Employer:	
(if different)			
		Referral #:	

Educational Information:

Current School:		School Address:	
Grade Level:			
		Teacher's Name(s):	
Classroom setting: (regular, special, inclusion, etc.)			
Has your child been previously evaluated at the school level?		<input type="checkbox"/> Yes* <input type="checkbox"/> No If Yes, please indicate when and by whom	
Has your child been previously evaluated thru a community resource?		<input type="checkbox"/> Yes* <input type="checkbox"/> No If Yes, please indicate when and by whom	
Check all areas assessed: <input type="checkbox"/> IQ <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Neurology <input type="checkbox"/> Achievement		<input type="checkbox"/> Speech/language <input type="checkbox"/> Physical therapy <input type="checkbox"/> Emotional/Mental Health <input type="checkbox"/> Other	

***If you answered yes, please provide copies of testing.**

Patient Name: _____

DOB: _____

Current Concerns:

What are your top 3 concerns/problems about your child?

- 1.
- 2.
- 3.

What specifically are you hoping to get from your visits with our office (i.e. evaluation, medication, 2nd opinion, behavior management, etc.?)

Anything additional you would like us to know about your child?

Medical Information:

Does your child currently take any medication, for any reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, which medication(s) and dosage	
Who is prescribing your child's medication?	
Is your child currently or previously received counseling services – either privately or through the school district?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please indicate counselor's name:	
When is the last time your child saw their primary MD?	

I understand that payment is expected at the time of service, unless I have made prior arrangements. I agree to pay all fees which incur from any visits to this office in which my insurance does not cover. I understand that failure to do so will result in being sent to the collection department. I also understand that missed appointments, or appointments cancelled less than 24 hours are subject to a charge of \$45.00.

Signature

Date

Office Staff only:

Insurance information Verified _____ Specialist Copay = \$ _____ MH Copay \$ _____

Intake Appointment: _____

Notes/Comments: _____