Stacie B. Isenberg, Psy.D., PLLC
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Patient Information -- Child/Adolescent

Patient Name _____ Date _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Pediatrician's Name _____

Name of Parent/Legal Guardian 1 _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

I consent to messages being left at: Home ☐ Cell ☐ Work ☐ Email*_____

**By providing email addresses I am giving Stacie B. Isenberg, Psy.D., PLLC permission to make contact via the email addresses. I understand that email cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or be incomplete, or contain viruses. I understand that Stacie B. Isenberg, Psy.D., PLLC does not accept liability for any errors or omissions which may arise as a result of email transmission.*

If there are any special instructions for Dr. Isenberg when leaving messages, please specify here: _____

_____

Name of Parent/Legal Guardian 2 _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

I consent to messages being left at: Home ☐ Cell ☐ Work ☐ Email*_____

If custody agreement in place, who has legal right to make healthcare decisions for child? _____

Are you covered by Medicare, Medicaid or Tricare? _____

(Please note that I do not accept any third party payment and have opted out of the 3 above. Any patient with these plans understands that they cannot be used).

Who referred you to Dr. Isenberg? _____

_____ _____

Signature Date