Ponderosa Counseling Center

Registration Form (Child/Adol)

PATIENT INFORMATION

Patient's Name: Last_____, First_____ MI_____

Date of Birth:___/___/____Home Phone: _____Cell Phone:_____

Address:_____

City:_____ State:_____, Zip Code:_____

PARENT INFORMATION

Mother's Name: Last_____, First: _____MI_____

Date of Birth:___/___/____Home Phone: _____Cell Phone:_____

Address:_____

City:_____ State:_____, Zip Code:_____

Employer: _____Work Phone:_____

Preferred Phone:_____Email:_____

Father's Name: Last_____, First: _____MI_____

Date of Birth:___/___/____Home Phone :_____Cell Phone:_____

Address:_____

City:_____ State:_____, Zip Code:_____

Employer: _____Work Phone:_____

Preferred Phone:_____ Email:_____

Parents: Married____ Separated_____ Divorced _____ Custody: _____

Siblings/Ages:_____

Insurance:_____ ID#:_____Group#:_____

Prescription Plan:_____

Preferred Pharmacy:_____

PRIMARY CARE PHYSICIAN

Doctor's Name:_____Phone:_____

Practice Name:_____

REFERRAL SOURCE

Name:_____ Phone:_____