571-309-7993 | Fax 800-387-5701
www.koehnconsulting.com | Koehndj2@gmail.com
8359 Beacon Boulevard, Suite 315 | Fort Myers, Florida 33907

Child/Adolescent Client Information Form

Client's Full Name:_____

Primary Address: (street/city/state/zip) _____

_____

If applicable, Client's Phone#_____ Client's Email _____

Date of Birth:_____ Age of Client:_____ Grade_____

Social Security #:_____Right or Left Handed_____

Relationship to Primary Insured:_____

Name of Pediatrician _____Phone#_____

How did you hear about us?_____

Reason for Referral:_____

_____

Parent/Guardian Information

Mother's Name_____ **Father's Name**_____

Address: _____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

Email address:_____ Email address:_____

Occupation: _____ Occupation:_____

Who does client live with (parent(s), grandparent(s), etc.)?_____

Name & Age of Siblings:_____

Insurance Information

Insurance Company:_____ Insurance Phone Number: _____

Subscriber's Name:_____ Subscriber's Birthdate:_____

Subscriber's Social Security #_____ Subscriber's Employer: _____

Subscriber's Address: _____

Member ID#_____ Group#_____

Specialist Copay:_____ Specialist Coinsurance:_____

PLEASE NOTE: In an effort to facilitate communication, [your company name here] sends **TEXT MESSAGE** confirmations the business day prior to the scheduled appointment. Our office will also **E-mail** receipts for payments or account statements to the provided E-mail address. Please indicate which phone number and E-mail address you would like to have notifications sent to on the line below. If you **do not** want to receive these communications, please write "I decline" on the line below:

Phone: _____ E-mail_____