CALIFORNIA ADHD CENTER FOR SUCCESS

12625 High Bluff Drive #201 * San Diego, CA 92130
Phone (858) 481-2188 * Fax (858) 400-5204

Patient Information

Today's date: _____

If patient is an adult, please complete this section. **If patient is a child, *parent* completes this section**:

Your name: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Driver's License _____ Exp: _____

Home address: _____
Street

_____
City State Zip

Marital status (please circle): S M W D Sep Name of spouse/partner: _____

Phone (home): _____ (cell): _____ (work): _____

Email: _____

Name of employer: _____ Occupation: _____

Referred by: _____ May we thank them? _____

Reason for referral: _____

Party responsible for account: _____ Relation: _____

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If child is the patient, please provide information below, otherwise skip this section:

Child's name: _____ Date of birth: _____ Age: _____

Parent's names: 1. _____ 2. _____

Child lives with: Both parents mother father other _____

Name of child's school: _____ Grade: _____

Current teacher (if in elementary school): _____ School phone: _____

Pediatrician: _____ Phone: _____

I agree to accept responsibility for payment at the time of service and for missed appointments or late cancellations (less than 24 hours notice). I am aware that I will be charged for missed appointments and/or late cancellations.

_____ _____
Signature Date