



THE ADHD CENTER FOR SUCCESS

office@theADHDcenterforsuccess.com www.theADHDcenterforsuccess.com

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: _____ Pronouns: _____

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: _____

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