



SOUTHWEST  
NEUROPSYCHOLOGY  
SERVICES

1515 E Missouri Ave Ste 111 • Phoenix, AZ 85014

## CHILD PATIENT REGISTRATION FORM

Name of person filling out this form (if not patient) \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of appointment \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Who is responsible for payment for services rendered? \_\_\_\_\_

### Patient Contact Information

Patient Mailing Address \_\_\_\_\_  
Street City State Zip

Phone Number Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Please circle preferred method of contact

Do we have your permission to leave a voicemail message for you at your home?  Yes  No

Do we have your permission to leave a message with a family member?  Yes  No

Do we have your permission to call you at your work?  Yes  No

### Work status

- Full time
- Part time
- Retired
- Not employed
- Disabled

Other contact person \_\_\_\_\_ Contact Phone \_\_\_\_\_

Tel. 602-274-1928 | Fax 602-274-7402

swnpoffice@gmail.com

www.swneuropsychology.com

Is an **attorney** involved in this case?  Yes  No Name \_\_\_\_\_ Phone \_\_\_\_\_  
If your attorney has not requested an independent examination, we will only be responding to the referral questions of your referring clinician. We might not address specific medico-legal questions your attorney may have. If you have any questions about this issue, you should contact your attorney.

Do you want a copy of your report sent to your attorney?  Yes  No

Is there a **guardian** for the patient?  Yes  No a **conservator**?  Yes  No

If yes, Name \_\_\_\_\_ Phone \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of patient/responsible party Date

### INSURANCE INFORMATION

If you are unable to bring your insurance card to your appointment, please complete the following.

**Industrial Injury?**  Yes  No If yes, Claim # \_\_\_\_\_

If industrial injury, Claims Representative Name: \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Carrier** (Health  Auto ) \_\_\_\_\_ Group Number \_\_\_\_\_

Name of insured \_\_\_\_\_ ID Number \_\_\_\_\_

Send Claim To \_\_\_\_\_  
Street City State Zip

**Secondary Carrier** (Health  Auto ) \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ ID Number \_\_\_\_\_

Send Claim To \_\_\_\_\_  
Street City State Zip