Jennifer Allen Norton, M.A., LPC-S

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CHILD \ ADOLESCENT INFORMATION FORM

PERSONAL DATA

NAME:_____ **DATE:** _____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:** _____

BIRTH DATE:_______________ **AGE:**_____ **SS #:** _____

SCHOOL:_____ **GRADE:**_____ **PHONE:**_____

TEACHER \ COUNSELOR:_____

PARENT \ MANAGING CONSERVATOR:

NAME:_____ **BIRTH DATE:**_______________

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:** _____

AGE:_____ **SS #:**_____ **MARITAL STATUS:** _____

PARENT \ CONSERVATOR EMPLOYMENT DATA

OCCUPATION:_____ **HOW LONG:** _____

PLACE OF EMPLOYMENT:_____ **EDUCATION:** _____

ADDRESS:_____ **PHONE:**_____

CITY:_____ **STATE:**_____ **ZIP:**_____

ADDITIONAL PARENT \ POSSESSORY OR JOINT CONSERVATOR \ STEP PARENT

NAME:_____ **BIRTH DATE:**_______________

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:** _____

AGE:_____ **SS #:**_____ **MARITAL STATUS:** _____

CHILD \ ADOLESCENT INFORMATION FORM 2/3

ADDITIONAL PARENT \ CONSERVATOR EMPLOYMENT DATA

OCCUPATION:_____ **HOW LONG:** _____

PLACE OF EMPLOYMENT:_____ **EDUCATION:** _____

ADDRESS:_____ **PHONE:**_____

CITY:_____ **STATE:**_____ **ZIP:**_____

SIBLINGS	BIRTH DATE	AGE	SEX	GRADE
_____	____________	_____	_____	_____
_____	____________	_____	_____	_____
_____	____________	_____	_____	_____
_____	____________	_____	_____	_____

MEDICAL DATA

FAMILY PHYSICIAN: _____

MEDICATIONS: _____

MEDICAL CONDITIONS OR DIAGNOSIS:_____

PRIOR TREATMENT: _____

INSURANCE DATA

INSURANCE CARRIER: _____

SUBSCRIBER'S NAME:_____ **DOB:**_____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

POLICY / ID NUMBER:_____ **GROUP NUMBER:**_____

CO-PAY AMOUNT:_____ **DEDUCTIBLE:** _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT

NAME:_____ **HOME PHONE:**_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

CELL PHONE:_____ **WORK PHONE:** _____

RELATIONSHIP:_____

I WAS REFERRED BY: _____

CHILD \ ADOLESCENT INFORMATION FORM 3/3

I AGREE TO BE RESPONSIBLE FOR ALL FEE'S INCURRED BY ME OR ON MY BEHALF FOR SERVICES RENDERED BY JENNIFER ALLEN NORTON, M.A., LPC-S. I UNDERSTAND THAT PAYMENT FOR SERVICES ARE DUE WHEN RENDERED AT AUSTIN, TEXAS.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE INFORMED CONSENT \ INFORMATION SHEET CITING THE PROCEDURES, SESSIONS, PRIVACY RULES, FEES, INSURANCE AND REFERRALS AS STANDARD POLICY AND I AGREE TO THE TERMS SET OUT THEREIN. I UNDERSTAND THAT IF A SUIT IS FILED TO COLLECT ANY UNPAID BALANCE ON MY ACOUNT, I AGREE TO PAY THE REASONABLE ATTORNEY'S FEES FOR SUCH PROCEDURES AND I AGREE VENUE IS ACCEPTABLE IN WILLIAMSON, COUNTY, TEXAS

_____ _____

SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE DATE