865 Eisenhower Blvd.
Johnstown, PA 15904

Behavioral Health

Pediatric Care Specialists

814-266-8840
fx 814-266-4922

Client Information 0-17 yrs

Patient Name____DOB___________________SS#_______-_____-_____________

Address____City_________________________ST______ZIP____________

County_____________________________

Email Address ____

Insurance Information

Primary Insurance____ID#__________________________

Responsible Party Name___________________________________DOB_________________Relationship__________________

Secondary Insurance______________________________________ID#__________________________

Responsible Party Name___________________________________DOB_________________Relationship__________________

Tertiary Insurance____ID#__________________________

Responsible Party Name___________________________________DOB_________________Relationship__________________

Bio Parent / Legal Guardian Information

Father ________________________________ Bio___ Legal Guardian___ DOB_____/_____/______ SS#_____/____/________

Address ____City_________________________ST______ZIP____________

Home Phone____________________________Cell Phone___________________________Work Phone____________________

Place of Employment____

Mother_______________________________ Bio___ Legal Guardian____ DOB_____/____/______SS#_____/____/_________

Address____City_________________________ST______ZIP____________

Home Phone____________________________Cell Phone___________________________Work Phone____________________

Place of Employment____

I acknowledge that all information provided is true and accurate. I must present the insurance cards and confirm the patients physical address at every visit. I understand that services may be terminated at any time if information is found to be inaccurate or withheld.

X____ **Print**___________________________________**Date**___________________