

capa child & adolescent psychiatry associates, pllc
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D. Andrew Elliott, M.D. _____

NEW PATIENT REGISTRATION

Please fill in ALL information

Name: _____ SS#: _____

Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Sex: _____ School: _____

Primary Care Physician: _____ Address: _____

May we notify the physician about your child's treatment? Yes No

Who referred you to our practice? _____

How would you like to be contacted or reminded of appointments? Home Phone #: _____

Cell Phone #: _____ E-mail address: _____

Parent/Legal Guardian Information

Father's Name: _____ Primary Phone # _____ Alt # _____

Father's Address: _____
Street City State Zip

Father's Occupation: _____ Employer: _____

Mother's Name: _____ Primary Phone # _____ Alt # _____

Mother's Address: _____
Street City State Zip

Mother's Occupation: _____ Employer: _____

Parents Married; No custody issues Parents Divorced; father custody Parents Divorced; mother custody Parents Divorced; joint custody Other _____

Who has physical custody? _____ Who makes medical decisions? _____

Who is authorized to pick-up prescriptions or correspondence? _____
Relationship to patient? _____

Financially Responsible Party and Insurance Information

Father Mother Both Other _____

Please provide information regarding insurance and/or health plan to be utilized:

Insurance: _____ ID# _____ Group # _____

Policy Holder: _____

Insured Social Security #: _____ Insured DOB: _____

Insurance Company Phone#: _____

XSignature: _____ Date: _____

Parent/legal guardian or Patient if 18 years of age