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NEUROPSYCHOLOGY ASSOCIATES, P.C.
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email: kempiak@neuropsychology-az.com

CHILD

Name _____ Date _____

Sex ____ Age ____ Birth Date ____ / ____ / ____ School _____ Grade ____

Pediatrician _____ **Referred by** _____

PARENTS/GUARDIANS

Is this child adopted? Yes No

Are custodial parents (circle one) together/separated/divorced If divorced, who has legal custody? _____

Mother/Guardian Name _____ (circle one) adoptive/biological/step-mother

Home Address _____
Street City State Zip

Father/Guardian Name _____ (circle one) adoptive/biological/step-father

Home Address _____
Street City State Zip

Who is responsible for payment for services rendered? _____

Contact Information

Name _____

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

Is there an **attorney** involved in this case? Yes No Name _____

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.

X _____

Signature of Responsible Party

Date