Tania Davidson, Psy.D.
580 Beech Avenue, Suite B
Carlsbad, CA 92008
(760) 729-5900

Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with Dr. Davidson. All information is CONFIDENTIAL.

Child/Adolescent's Name (First, Middle Initial, Last)

____

Parent(s): ____

Address____

City/State/Zip____

Phone #s: Home ____

Work____

Other (specify – cell phone, pager,

etc.)____

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No____ Yes____ (If Yes, please be specific) ____

Age_________ Birth Date________________ Social Security # _______________________________

School: ____ **Grade:** ____________________

Parent(s):

Single____ Married____ (# years_______) Partnered____ (# years_______) Separated____ Divorced____

Widowed____ Other____ (specify)____

Names and ages of other children____

Spouse's/Partner's Name____

Spouse's/Partner's Occupation____

Significant medical problems your child has or had: _______________________________________

____

Current Physician: ____

Current medications child is taking____

If your child has had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

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If you are currently working with any other mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

____

____

____

____

Primary Insurance Information
Insurance Company and Type (HMO, PPO, etc.) ____

Member ID #_________________________________

Group/Plan#_________________________________

Insurance Phone # (for benefit or claims information from your card)

____

Claims address (from your card)
____

____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name____

Address & Phone # (only if different than yours)____

____

Birth Date____________________ **Social Security #** _______________________________

Employer____

Your relationship to policy holder____

PLEASE PROVIDE YOUR INSURANCE CARD TO BE COPIED

SIGNATURES

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information to Dr. Davidson as soon as possible.

____ _________________________

Client Signature **Date**

CLIENTS USING INSURANCE ALSO SIGN IN BOTH PLACES BELOW
I authorize the release of any clinical, benefits or other information between Tania Davidson, Psy.D. and my insurance company/companies that is necessary to process insurance claims for me or my dependents. Clinical information may include current and/or past symptoms, previous mental health treatment, diagnosis/diagnoses, treatment plan and/or goals, progress reports, copies of clinical notes or other clinical information.

____ _______________________________

Client Signature or Parent/Guardian Signature for Minors **Date**

I authorize payment of health insurance benefits to Tania Davidson, Psy.D.. for services provided.

____ _______________________________
Client Signature or Parent/Guardian Signature for Minors **Date**

For co-payments and/or services not covered by insurance, the following information is needed:

Client Name: ____

Name on Card: ____

Date: ____

Type of Card: VISA ❒ MasterCard ❒ Exp. Date: ______/_______

Card Number: _________________-__________________-__________________-_________________

Verification/Security Code (3 digit code on back of card by signature line):__________________

Billing Address:____

City:___________________________ State: ________________________ Zip:___________________