CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA (CAPP)

PATIENT DATA SHEET

The information listed below will be used by CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA (CAPP) for billing purposes only. All information is kept in strict confidence.

(Please print)

[A] PATIENT INFORMATION: This section pertains to the patient. If the patient is a minor or dependent,														
information about the parents is also required (Section B).														
Referred by	Referred by Referred by					Referred to (CAPP Therapist/Physician Name)						Today's Date		
												/	,	/
Patient's Name (last, first, m.i.)										Date of birth				
												/	/	/
Address							City					State	Z	ip
Home phone			Cellu	ılar phon	e (OK	to te	xt?	Y / N)	E-	mail		1	
()			()										
Fax number			Sex	x	Male	e		Marital	Stat	us		Single		Married
()					Fem	ıale					1	Divorced		Widowed
Employer (If patient is a stude	nt, list i	name of	schoo	l here)		Business				ess pl	phone			
						(
Employer address, city, state, z	zip								I					
Spouse Name					E-ma	ail					Date of Birth			
												/		/
Spouse Employer Business or Cellular phone								e						
1 1 7						()			
Spouse Employer address, city	state 2	zin										<u>, </u>		
Spouse Employer address, etcy	, state, z	21P												
[B] IF THE PATIENT	IS A N	INOI	R OR	DEPE	NDE	NT,	PA	RENTS	S C	OMP	LET	TE THE	FΟ	LLOWING:
MOTHER'S Name (last, first, r	n.i.)					FATHER'S Name (last, first, m.i.)								
	. ,									-,,				
Address (if different than above)						Address (if different than above)								
radiess (ii different than abov	C)					riuc	11033 (ir dirici	CIII ti	nan ao	000			
City		State		Zip		City	7					State		7in
City		State		Zip		City	′					State		Zip
D. (CD' 1	F '1					D.4	C T	11.		1	Е	. 11		
Date of Birth	E-mail					Date	e of B	irtn	,		E-ma	a11		
/ /							/	/				1		
ome phone or fax number Cellular phone (ok to to			(ok to text	(?Y/N) Home ph			one or fax number				Cellular phone (ok to text?Y/N)			
)			()					()			
Employer Employer														
Business phone Occupat			on			Business phone					Occupation			
Parents' Marital Status to each other: Married Separated Divorced Other:														
If parents are separated or divo	rced, cl	neck her	e if ea	ch parent	shoul	d rec	eive a	copy of	the	month	ly bil	l: 🔲		

	CIAL RESPONSIBILITY: The per or payment of the account. All bills and co	8		•					
Name	01 puly 2220120 02 1220 wood 02200 1211 22112 0220 02		Daytime phone	ness outer wise specifical					
			()						
Address		City	State	Zip					
		j		1					
[D] INSUR	ANCE: It is the policy of CAPP not to	o file claims unless required	d to do so by cont	ractual agreement					
	rance company. Please complete this s	-	•						
Insurance Comp	pany			<u> </u>					
Insured / Policy	holder's Name	ID / Subscriber Numb	per						
Group Number		Provider / Customer S	Provider / Customer Service Phone Number						
		()							
[E] EMER(GENCY INFORMATION: In case	we are unable to contact vo	ou at one of the ni	ımhers indicated on					
	e list the nearest relative or close friend		ou at one of the ne	misers maleated on					
Name		Relationship to patier	nt Daytime pho	Daytime phone					
			()						
[F] I CERTI	IFY THAT I HAVE BEEN INFORM	ED AND UNDERSTAND T	THAT MY CAP	P PHYSICIAN					
	D AND REGULATED BY THE MED								
	R TO FILE A COMPLAINT GO TO:		•	ECK OF ON A					
	IECK@MBC.CA.GOV OR CALL (8		JI LIVIAIL.						
Guarantor Sign		Relationship to patier	nt Date						
Suarumor Sign	uure	relationship to patien							
[C] I CEDTH	FY THAT I HAVE BEEN PROVIDED INF		WDITTEN CODY	OF THE CHILD &					
	CHIATRISTS OF THE PENINSULA								
	AND HOW THIS PERTAINS TO PROTEC								
	VED THE FOLLOWING NOTICE INCLU								
FEDERAL TO	OL USED TO SEARCH PAYMENTS MAD	E BY DRUG AND DEVICE C	OMPANIES TO PH	IYSICIANS AND					
TEACHING H	OSPITALS. IT CAN BE FOUND AT HTT	PS://OPENPAYMENTSDATA	CMS.GOV "						
Guarantor Sign	ature	Relationship to patier	nt Date						
For CAPP use	e only:								
Child & Adult	t Psychiatrists of the Peninsula has made	a good faith affart to obtain	the above calmony	ladgament At this					
	wing circumstances exist:	a good faith effort to obtain	the above acknow	leugement. At uns					
The guarantor or patient declines to sign									
	The patient is not able to sign and there is no legal representative available								
	- F								
Date	 Time	Signature of CAPP emplo	W100						
	Lima	SIGNALITY OF L APP AMAIA							