UC IRVINE CHILD DEVELOPMENT SCHOOL
New Patient Information Sheet

PATIENT (legal name): _____ **Age:** ___ **DOB:** ___/___/___ **Sex:** M / F

Home address _____**City**_____ **ZIP**_____

Social security #_____/____/____ **Home phone:** _____ **Cell:** _____

Current School _____ **Current Grade** ____ **Grade in Fall** _____

School District _____

MOTHER/Legal Guardian Name_____ **Date of birth**____/____/____

Home address (*if different from patient*)_____
Street City Zip

Social security #_____/_____/_____ Home phone: _____ Cell: _____

E-mail:_____ Work phone: _____ Occupation :_____

Employer Name/Address _____ City_____ ZIP_____

Employed Full Time____/Part Time____ Primary Contact Number (*check one*): ☐ Home ☐ Cell ☐ Work

FATHER/Legal Guardian Name_____ **Date of birth**____/____/____

Home address (*if different from patient*)_____
Street City Zip

Social security #_____/_____/_____ Home phone: _____ Cell: _____

E-mail:_____ Work phone: _____ Occupation:_____

Employer Name/Address_____ City_____ ZIP_____

Employed Full Time____/Part Time____ Primary Contact Number (*check one*): ☐ Home ☐ Cell ☐ Work

Name of emergency contact _____ Relationship to patient _____

Home address_____City_____ ZIP_____

Home phone: _____ Cell: _____ Work: _____

***If the parents (above) are legally divorced or separated, indicate the current court-ordered custody agreement:**

☐ Not Applicable – Parents are Married

☐ Joint (shared) Legal Custody *(details)*: _____

☐ Joint Physical Custody *(details):* _____

☐ Mother Sole (Full) Legal Custody

☐ Father Sole (Full) Legal Custody

☐ Other *(details):* _____

**Written consent from parent with sole legal custody for health care decisions or from both parents sharing legal custody is required prior to services for the above named minor to receive mental health examinations, diagnostic procedures, and/or treatment at the UC Irvine Child Development School.*