

# Adolescent & Young Adult Medicine, P.S.

James H. States M.D.

P.O. Box 12257 • Olympia, WA 98508

Telephone: (425) 646-0804 • Fax: (206) 202-1985

## DEMOGRAPHIC INFORMATION (please complete all fields)

<b>PATIENT'S LEGAL NAME:</b> _____			
_____	_____	_____	_____
Address:	_____	_____	Apt. #: _____
City:	_____	State: _____	Zip: _____ Home Phone: _____
Date of Birth:	____/____/____	Sex: M F	SS#: _____ Cell Phone: _____
Patient's Primary Doctor:	_____	Doctor's Phone _____	Doctor's Fax: _____
<b>INSURED NAME:</b> _____			
_____	_____	_____	_____
Address:	___ Same as patient / or _____	_____	_____
Home Phone:	_____	Cell Phone: _____	Date of Birth: ____/____/____
Sex: M F	SS#: _____	Relationship to Patient: _____	_____
Insurance Company:	_____	Mental Health Benefit Provided By: _____	_____

<input type="checkbox"/> Mother
<input type="checkbox"/> Step Mother

### MOTHER

\_\_\_\_\_

\_\_\_\_\_ *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ *Last*

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_ Same as patient / or: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Years at Present Employer: \_\_\_\_\_

<input type="checkbox"/> Father
<input type="checkbox"/> Step Father

### FATHER

\_\_\_\_\_

\_\_\_\_\_ *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ *Last*

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_ Same as patient / or: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Years at Present Employer: \_\_\_\_\_

### Person not living at your address to contact in case of emergency:

Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____

I hereby authorize Adolescent and Young Adult Medicine, P.S. to release any medical, psychological, and psychiatric information necessary to process claims with any insurance companies. I also assign Adolescent and Young Adult Medicine, P.S. all payments to which I am entitled for medical, psychological, psychiatric, and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I hereby authorize the doctors, counselors and therapists of Adolescent and Young Adult Medicine, P.S. to provide such medical, psychological, and psychiatric services, either regular or emergency, as may be determined to be in the best interest of those members of my immediate family or myself, as listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

Signature (Patient/Parent/Guardian): \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Please Print: \_\_\_\_\_