7601 Conroy Windermere Rd.
Suite 203
Orlando, FL 32835

Telephone: 407-704-1461
Fax: 407-704-1501
www.happymindcompany.com

PLEASE COMPLETE IN FULL / PRINT CLEARLY

Patient's Full Name (Last, First, Middle Initial):_____, _____, _____

Address: _____ City/State/Zip:_____

Home Phone:_____ Parent's Work Phone:_____ Cell:_____

Where May We Contact You? Home ☐ Work ☐ Cell ☐

Patient's Date of Birth:_____ Age:_____ Social Security #:_____

School:_____ Grade:_____ 504 or IEP in place? Yes / No

Do Both Parents Live in the Same House? Yes / No

Parent's or Legal Guardian's Name: (Must Be Completed)_____

Parent/Legal Guardian Employer:_____ Occupation:_____

Person Responsible for Account:_____ Relationship to Patient:_____

Address (if different):_____ City/State/Zip_____

Home Phone (if different): _____ Work Phone: _____

Name and Phone Number of closest relative/friend NOT living with you:_____

Emergency Contact:_____ Relationship to patient_____

Emergency Contact Phone #_____

How Were You Referred To This Office?_____

In the unfortunate event that this account is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and costs of collection. Also, an additional fee of 40% of the amount owed will be added for collection charges.

Please be sure to review and acknowledge The Happy Mind Company's *Financial*, *Medication* and *Practice Policies*.

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 48 HOURS NOTICE; OTHERWISE, A *$75.00* CHARGE WILL BE IIMPOSED FOR THE TIME RESERVED.

I certify that all information on this page is true. I have read and understand and agree to the above.

Signature:_____ Printed Name:_____

Relationship to Patient:_____ Date:_____

***If legal guardian, please present guardianship paper to receptionist**