BEHAVIORAL HEALTH SERVICES
Pediatric Care Specialists

865 Eisenhower Blvd
Johnstown, PA 15904
Phone: 814-266-8840
Fax: 814-266-4922

Client Information

Patient Name:_____ DOB:_____

Address:_____ Age: ____ SSN#_____

City:_____ ST_____ ZIP_____ County:_____

Home Phone:_____ Cell Phone:_____

Primary Care Physician & Practice Name:_____

Parent / Guardian Information
(Whom child resides with)

Father / Guardian Name:_____ Bio __ Step __ Foster__ Other_____
Address:_____ DOB:___/___/_____ SSN#_____
City:_____ ST _____ ZIP_____ Cell Phone: _____
Home Phone:_____ Work Phone:_____

Mother / Guardian Name:_____ Bio __ Step __ Foster __ Other_____
Address:_____ DOB:___/___/_____ SSN#_____
City:_____ ST _____ ZIP_____ Cell Phone:_____
Home Phone:_____ Work Phone:_____

Biological Parent Information
(If same as above or in case of adoption, DO NOT COMPLETE)

Father Name:_____ DOB:___/___/____SSN#_____
Address:_____ Home Phone:_____
City:_____ ST _____ ZIP _____ Cell Phone:_____

Has custody been revoked by the courts? **YES OR NO**

Mother Name:_____ DOB:___/___/____SSN#_____
Address:_____ Home Phone:_____
City:_____ ST _____ ZIP_____ Cell Phone:_____

Has custody been revoked by the courts? **YES OR NO**

Is there a legally signed court order in place stating custody arrangements? YES OR NO

I acknowledge that all information provided is true and accurate. I understand that services may be terminated at any time if information is found to be inaccurate or withheld.

X_____ **DATE:**_____