



cayenne

wellness center and children's foundation

208 south louise street

glendale, ca 91205

usa

www.cayennewellness.org

PATIENT INFORMATION - MINOR FORM

1. NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

SS# OF PATIENT: _____ - _____ - _____

2a. NAME OF PARENT/GUARDIAN: _____ **DATE OF BIRTH:** _____

SS# OF PARENT/GUARDIAN: _____ - _____ - _____ **DRIVER'S LICENSE NUMBER:** _____

2b. NAME OF PARENT/GUARDIAN: _____ **DATE OF BIRTH:** _____

SS# OF PARENT/GUARDIAN: _____ - _____ - _____ **DRIVER'S LICENSE NUMBER:** _____

3. ADDRESS OF PATIENT: _____

CITY/STATE: _____ **ZIP CODE:** _____

3a. ADDRESS OF PARENT/GUARDIAN in 2a (if different from patient): _____

CITY/STATE: _____ **ZIP CODE:** _____

3b. ADDRESS OF PARENT/GUARDIAN in 2b (if different from patient): _____

CITY/STATE: _____ **ZIP CODE:** _____

4. TELEPHONE NUMBERS AND E-MAIL OF PATIENT:

PATIENT HOME: _____ **PATIENT WORK:** _____

PATIENT CELL: _____ **PATIENT E-MAIL:** _____

4(a) (b). TELEPHONE NUMBERS AND E-MAIL OF PARENT/GUARDIAN:

2a. GUARDIAN/PARENT HOME : _____ **WORK:** _____

CELL: _____ **E-MAIL:** _____

2B. GUARDIAN/PARENT HOME : _____ **WORK:** _____

CELL: _____ **E-MAIL:** _____

PERMISSION TO TREAT

Permission is hereby given to Cayenne Wellness Center and Children's Foundation to render treatment and/or service to: _____ .
patient's name

Permission is further given for Cayenne Wellness Center and Children's Foundation to exchange information regarding _____ with
patient's name

Name of agency

Address of agency

City, State and Postal Code

Telephone number of agency

Contact Name

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

SIGNATURE OF THERAPIST: _____ DATE: _____