New Patient Information

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| Date: | |  |
| Child’s Name: | |  |
| DOB: Age: | |  |
| Parent #1’s Name (M/F): | | |
| Parent #2’s Name (M/F): | | |
| Address: | City and Zip code: | |
| Home Number: |  | |
| Parent #1’s Cell: | Parent #2’s Cell: | |
| Parent #1’s Email: Parent #2’s Email: | | |
| Referred By: Pediatrician: | | |
| State the concerns you have about your child: | | |

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| What would you like help with? |
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| Has your child been given a diagnosis? If so, what is the diagnosis? |
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| Has your child had any testing? This may include Developmental testing, Regional Center/IEP evaluation, Neuropsych evaluation. Please give dates and name of the provider/agency who performed the tests: |
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| Does your child receive or has your child received any therapy services such as OT, PT, CBT, etc…? |
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| School: |
| Grade: Public or Private School: |
| Does your child nap Y / N. If yes, what time? |

Please fax completed form to (310)996-8991 **or** email to [assistant@dbpeds.com](mailto:assistant@dbpeds.com).

**Dr. Mandelberg is not a provider with any insurance company**. We ask that visits are paid at the time of service and we will provide you with a super bill to submit for insurance reimbursement.

All forms are reviewed by Dr. Mandelberg before appointments are scheduled. Please allow 2-3 business days for a response from our office.