



Children's Center
for
Therapy and Learning

Patient Registration Form

Today's date _____

Speech Occupational Physical Tutoring Behavioral

Child's Information

Child's Name: _____ Child's SS#: _____

Date of Birth: _____ Gender: M- / F- School Name: _____

Home Address: _____ School address: _____

Referred By: _____

Previous Therapy? Yes / No If yes, where? _____

Parent's Information _____ Parent's SS# _____

Parent's Name: _____ : Mother- / Father-

Home Address: _____ City _____ State _____ Zip _____

Home phone _____ Cell Phone: _____ Work Phone: _____

Email Add. _____ do you check it often? _____ Would you like billing via email? Yes / No

Physician Information

PCP Name: _____ Office Phone#: _____

Office Address: _____ City _____ State _____ Zip _____

Referring Physician: _____ Office Phone#: _____

Office Address: _____ City _____ State _____ Zip _____

Insurance Information

Insurance Co.: _____

Policy Holder: _____

Member/Policy#: _____

Ins. Phone #: _____

Explained billing policy? Yes No

OFFICE Use:

Availability: _____

Intake paper work on: _____

Follow up Contacts

1 _____

2 _____

3 _____

Sent to inactive - Date: _____ By: _____