CHILD REGISTRATION

Date:

Child's Name:	M☐ F☐	DOB:	
Address:		SS#:	
City,State,Zip:	Phone:	Cell:	
Physician:	Physician's Phone:		
School:	Teacher:		
Student Status: ☐Full ☐Part ☐Not A Student ☐Other		Grade:	
Referred By:			

Parent/Guardian Information:

Mother's/Guardian Name:		DOB:
SS#:	Relationship:	Home Phone:
Address: (if different from above)		Cell:
Employer: ☐ Full Time ☐ Part Time		Work Phone:
Emergency Contact:		Marital Status:
Relationship: Phone:		Work Phone:
Father's/Guardian Name:		DOB:
SS#:	Relationship:	Home Phone:
Address: (if different from above)		Cell:
Employer: ☐ Full Time ☐ Part Time		Work Phone:
Emergency Contact:		Marital Status:
Relationship: Phone:		Work Phone:

Insurance Information - Primary

Name of Insurance Plan:	
Certificate/ID Number:	Group Number:
Subscriber:	Relationship to Child:
Subscriber's SS#:	Subscriber's DOB:
Subscriber's Employer:	Work Phone:
Secondary Insurance	
Name of Insurance Plan:	
Certificate/ID Number:	Group Number:
Subscriber:	Relationship to Child:
Subscriber's SS#:	Subscriber's DOB:
Subscriber's Employer:	Work Phone:

I have been advised by (PROVIDER) to obtain an authorization from my insurance carrier or notify them of my treatment. If I fail to do this I could be financially responsible for services rendered. I authorize (PROVIDER) to release information to my Insurance company in order to obtain payment or authorization for services. I understand and give permission that (PROVIDER) may be required by my insurance company to release personal and otherwise confidential information. I absolve (PROVIDER) from any responsibility for any misuse of confidential information by my insurance company, including but not limited to the sharing of information with other insurance companies and with employers. I authorize payment to go directly to (PROVIDER). I acknowledge the receipt of the Notice of Privacy Practices for (PROVIDER).

X _____ X _____

Signature of Client, Parent, or Guardian Print Name: Date