CHILDREN'S THERAPY SPECIALISTS

REGISTRATION FORM

PATIENT INFORMATION: **DATE:**

CHILD'S NAME: ____
LAST FIRST MI

DATE OF BIRTH: _______/ _______/ ________ SEX: M F

ADDRESS: ______________________________CITY: __________STATE:_____ZIP_____

MEDICAL DIAGNOSIS: __________________________
Precautions for Therapy: ____
Any Known Allergies (i.e. food, latex):__________________________________

How did you hear about us: *physician* *school staff* *friend*

insurance company *internet search*

INSURANCE

PRIMARY INSURANCE:________________________Phone Number:________________

POLICY ID NUMBER: __________________________GROUP NUMBER:________________

POLICY HOLDER: ____________________________RELATIONSHIP TO PATIENT:__________

POLICY HOLDER'S DATE OF BIRTH: _______/_______/________

POLICY HOLDER'S SS# _______-________-_______ EMPLOYER:________________

SECONDARY INSURANCE: ______________________ Phone Number: ________________

POLICY ID NUMBER: __________________________GROUP NUMBER: ________________

POLICY HOLDER: ____________________________RELATIONSHIP TO PATIENT: __________

POLICY HOLDER'S DATE 0F BIRTH: _______/_______/________

POLICY HOLDER'S SS# _______-________-_______ EMPLOYER: ________________

MINNESOTA MA: YES NO ID#______________________________

YOUR HEALTH CARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION. YOU MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES PROVIDED.