CHILDREN'S THERAPY SPECIALISTS

REGISTRATION FORM

PATIENT INFORMATION: **DATE:**

CHILD'S NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____/ _____/ _____ SEX: M ◯ F ◯

PARENT(S) NAME: _____

ADDRESS: _____CITY: _____STATE:_____ZIP_____
PHONE NUMBER:
_____

PARENT EMAIL ADDRESS:
_____

PRIMARY PHYSICIAN:_____
CLINIC NAME:_____
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*

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: _____

YOUR INSURER OR PLAN MAY REQUIRE A REFERRAL OR PRIOR AUTHORIZATION BEFORE SPEECH THERAPY SERVICES ARE PROVIDED. INSURANCE WILL BE BILLED IF INFORMATION IS PROVIDED. THE PATIENT IS RESPONSIBLE FOR PARTIAL OR COMPLETE PAYMENT FOR ANY SERVICES PROVIDED.
PARENT INITIAL/SIGNATURE:_____