Children's Registration Form 2

Date________________

DX Code ________________
Therapist________________
Location ________________

Patient's Information

Patient Name (Print)____________________________ __Date of Birth____________________
Last Name First Name Initial
Street Address:______________________________ Home Phone { }________________
City____________________________________ State________ ZIP_____________________
Gender: Female Male Age___________
Mother's Name: _________________________ Phone(s) (H/W/C): _________________________
Father's Name: _________________________ Phone(s) (H/W/C): _________________________
Parent Address (if different): ____________________________ City___________ State ____ Zip____

Primary Insurance

Primary Insurance Company: _____________________________ Phone { }_________________
Address Ins Claim_____________________ City_____________ State_______ Zip__________
Policy/ID #_________________________________ Group/Plan #__________________________
(Policy Holder's social security number.)
Policy Holder Information: (if the patient is not the employee/policy holder)

Name____ Relationship ______________
Last name First Name Initial
Address______________ City____________ State____ _Zip______ Date of Birth__________
Soc. ec#______________________ __Employer_______________________________________

Secondary Insurance

Secondary Insurance Company:__________________________ Phone { }__________________
Address- Ins.Claim_______________ _City_____________ State_______ Zip____________
Policy/ID #________________________________Group/Plan #______________________________
(Policy Holder's social security number.)

Policy Holder Information

Name____ _Relationship ____________
Last name First Name Initial
Address_________________ City____________ State_____ Zip____ DOB ____________

Responsible Party for Billing

Name _______________________________ Relationship ______________________
Address: ___________________________ _ _Phone { }_____________________
E-mail Address ____

Agreement and Release

____________________, certify that I (or my child/guardian) have insurance coverage as noted above. I have directly authorized the healthcare provider listed above all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges my insurance did not pay. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements to me at my address. I authorize the use of my signature on any insurance submissions.

________________________________ _______________________ _____________________
Name/Signature Responsible Party Relationship Date