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REGISTRATION FORM: CHILD/ADOLESCENT

Date:_____

Child's Name:_____Date of Birth:_____Age:_____

Address:_____

Town: _____State:_____Zip:_____

School:_____Grade:_____

Did anyone refer you to this practice?_____

Information regarding mother:

Name:_____Date of Birth:_____Age:_____

Home address (if different from above)_____

Town:_____State:_____Zip:_____

Primary phone contact:_____Other phone:_____

(Indicate if mobile, home or work)

May I contact you by email? If yes, **email address**: _____

Information regarding father:

Name_____Date of Birth_____Age:_____

Home address (if different from above):_____

Town:_____State:_____Zip:_____

Primary phone contact:_____Other phone:_____

(Indicate if mobile, home or work)

May I contact you by email? If yes, **email address**: _____

Others living in the home

Name:_____Relationship:_____Age:__

Name:_____Relationship:_____Age:__

Name:_____Relationship:_____Age:__

Name:_____Relationship:_____Age:__

Name:_____Relationship:_____Age:__

Name:_____Relationship:_____Age:__

Physician:_____Phone number:_____

Address:_____

Insurance information: Primary

Insured's name:_____**Date of birth**:_____

Relationship to client: _____Self: _____Spouse:_____Child: _____Other:_____

Insurance company:_____Company phone:_____

Insured's ID number:_____Group/policy number:_____

Insurance information: Secondary

Insured's name:_____Date of birth:_____

Relationship to client: _____Self _____Spouse_____Child _____Other:_____

Insurance company:_____Company phone:_____

Insured's ID number:_____Group/policy number:_____