



info@kidsplacetherapy.com Phone: 630-347-1702 Fax: 847-378-4615

Today's Date: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME: _____ SEX: _____ DOB: _____
LAST FIRST MI M/F MO DAY YR

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

REFERRING PHYSICIAN NAME/PHONE: _____

PRIMARY PHYSICIAN NAME/PHONE: _____

ALLERGIES/PRECAUTIONS:

Does your child have any allergies, seizures or precautions? If so, please list and describe:

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN)

NAME: _____ DOB: _____
LAST FIRST MI MO DAY YR

RELATION TO PATIENT: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

PHONE: _____ EMAIL ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: Phone Email Mail

NAME: _____ DOB: _____
LAST FIRST MI MO DAY YR

RELATION TO PATIENT: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

PHONE: _____ EMAIL ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: Phone Email Mail

INSURANCE

PRIMARY INSURANCE: _____ INSURANCE PHONE: _____

POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI

RELATION TO PATIENT: _____ DOB: _____
MO DAY YR

POLICY NUMBERS: _____
(ID #) (GROUP #)

SECONDARY INSURANCE: _____ INSURANCE PHONE: _____

POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI

RELATION TO PATIENT: _____ DOB: _____
MO DAY YR

POLICY NUMBERS: _____
(ID #) (GROUP #)

