CENTER FOR SPEECH, LANGUAGE, AND LEARNING INC.

Registration Information

Child's Name:	**Today's Date:**
Date of Birth:	Sex: **M / F**
Address:	
City:	State/Zip:
Clinic/Program Site Name:	

Parent:	DOB:
Address:	
City:	State/Zip:
Home Phone:	**Cell Phone:**
Place of Employment:	Work Phone:
Education:	**Parent Email Address:**

Parent:	DOB:
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
Education:	Parent Email Address:

INSURANCE INFORMATION:	
Primary Insurance Company: ****	Group Number:
Policy Holder:	ID Number:
Employer:	Subscriber Social Security Number:
Secondary Insurance Company:	Group Number:
Policy Holder	ID Number:

REGISTRATION INFORMATION CONTINUED

Primary Care Physician: _____

Name of Clinic: _____

Address: _____

Phone: _____

Fax: _____

EIDBI DX: _____

******PLEASE INITIAL:** _____

IMPORTANT NOTE: ANY/ALL insurance changes must be promptly reported to CSLL.
Unreported insurance changes may result in sudden discontinuation of services.

Would you like information on community resources? o Yes o No
Do you currently work with a social worker or case manager, and if so, would you provide their name(s) and permission to contact them? o Yes o No
Name and contact information: _____

Please list other individuals who are involved in taking care of the patient, such as spouse or caregiver, with whom you authorize **Center for Speech, Language and Learning, Inc**. to discuss the patient's treatment or release child into the care of in case of emergency.

NAME:
_____

RELATION TO PATIENT:
_____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

DAY PHONE: (_____) _____ EVE PHONE: (_____) _____

CELL PHONE: (_____) _____ EMERGENCY CONTACT: ____YES____NO