CENTER FOR SPEECH, LANGUAGE, AND LEARNING INC.

Registration Information

Child's Name:	Today's Date:
Date of Birth:	Age:
Address:	
City:	State/Zip:
Who does the child lives with?	

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:
Employer	Subscriber Social Security Number

REGISTRATION INFORMATION CONTINUED

Primary Care Physician: _____

Name of Clinic: _____

Address: _____

Phone Number: _____

Fax Number: _____

*please list other physicians involved in your child's care:

_____

_____

Would you like information on community resources? ☐ Yes ☐ 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? ☐ Yes ☐ 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

HOW DID YOU HEAR ABOUT US?

_____Phonebook

_____Website

_____Friend_____

_____Doctor _____

_____Other_____