PATIENT REGISTRATION

Date:_____

PATIENT INFORMATION

Child's First Name:_____Middle Initial:_____Last Name:_____

Child's Birthdate:_____ Pediatrician:_____

Parent/Guardian's Names:_____

Mailing Address:_____City:_____Zip:_____

Phone (Home):_____(Work):_____ (Cell):_____

Emergency Contact:_____Phone:_____

Email address:_____

CLINICAL INFORMATION

Please state briefly your area/s of concern for your child (use back of page if necessary)

_____

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance Company:_____ Phone #:_____

Name of Policy Holder:_____

Policy Group #:_____ Policy ID #:_____

Policy Holder's DOB:_____ Relationship to Patient:_____

☐ *I do not have secondary insurance*

☐ *I do have secondary insurance with:* _____

ASSIGNMENT & RELEASE

I, the undersigned certify that my child has insurance coverage with the insurance company listed above, and assign directly to Janet L. Shefferly OTR/L, INC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

_____ _____

Parent's Signature Date