CENTER FOR THERAPEUTIC INTERVENTION

PATIENT REGISTRATION

Patient Name_____ Birthdate_____

Address_____

_____

Home Phone_____ Referring Physician/Pediatrician_____

Email Address to Receive Statements_____

PARENT INFORMATION

Parent Name_____ DOB_____ Home Phone_____

Address (if different from patient)_____

Cell Phone_____ Work Phone_____

Occupation_____ Employer_____

Parent Name_____ DOB_____ Home Phone_____

Address (if different from patient)_____

Cell Phone_____ Work Phone_____

Occupation_____ Employer_____

Emergency Contact_____ Phone Number_____

Relationship to Patient_____

Primary Insurance

Insurance Company_____ Provider Phone Number_____

Policy/ID Number_____ Group Number_____

Subscriber Name_____ DOB_____ Employer_____

Secondary Insurance

Insurance Company_____ Provider Phone Number_____

Policy/ID Number_____ Group Number_____

Subscriber Name_____ DOB_____ Employer_____

I understand that I will be responsible for payment of all services rendered. I hereby authorize CENTER FOR THERAPEUTIC INTERVENTION to furnish the insurance company with any requested information. I authorize payment of medical benefit to CENTER FOR THERAPEUTIC INTERVENTION for any services rendered.

Signature of Parent/Guardian_____ Date_____

Printed Name of Parent/Guardian_____