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Registration Form

Client/Patient Information

Child's Name: _____ Date: _____

Gender: M F Age: _____ years _____ months D.O.B.: _____

Address:_____

School: _____ Grade: _____

Parent/ Legal Guardian Contact Information

First Guardian

Name: _____ D.O.B.: _____

Age: _____ Relationship to Child: _____

Address: _____

Phone Number: _____Alternate Number: _____

Marital Status: _____

Custody Status of child (if divorced or separated):_____

Second Guardian

Name: _____ D.O.B.: _____

Age: _____ Relationship to Child: _____

Address: _____

Phone Number: _____Alternate Number: _____

Martial Status: _____

Custody Status of child (if divorced or separated):_____

Patient's Siblings and Others Who Live in the Household

Name(s) _____

Relationship(s) _____

Age(s)_____ Gender(s)_____

Medical Information

Referred by: _____ PCP:_____

Current Medications including Supplements:_____

_____

Health or Medical Issues: _____

_____

*EMERGENCY CONTACT: _____

Relationship: _____ Phone Number: _____

*Please fill out an authorization to release information form for this person