the hello CLINIC
speech & occupational therapy

Client Registration Information

CLIENT INFORMATION

Client Name:_____Today's Date:_____
DOB:_____Age:_____Sex:_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:_____ DOB:_____
Address:_____
City:_____State:_____ Zip Code:_____
Phone (home):_____ Phone (cell):_____
Email:_____Employer:_____

Other Parent/Guardian Name:_____ DOB:_____
Address:_____
City:_____State:_____ Zipcode:_____
Phone (home):_____ Phone (cell):_____
Email:_____Employer:_____

BILLING INFORMATION

Insurance Company:_____
Insured's Name:_____Relationship of Insured to Client:_____
ID #:_____Group #_____
Insurance Company Phone Number:_____
If Insurance will not pay for cost of services; will pay for services (circle one) YES NO
Pediatrician referring _____

HOW DID YOU HEAR ABOUT THE HELLO CLINIC?

Who can we thank for your referral?_____
_____