



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 _____