

## CHILD REGISTRATION FORM

**Child's Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_ Male / Female: \_\_\_\_\_

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Address of Child: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parents Married: \_\_\_\_\_ Years Divorced: \_\_\_\_\_ Years

**Father's Name:** \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education (school/degree): \_\_\_\_\_

Father's Health Problems: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education (school/degree): \_\_\_\_\_

Health Problems: \_\_\_\_\_

**Bill To:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_