Pediatric Therapy Link of North Alabama, LLC
97 Hughes Rd, Suite H; Madison, AL 35758

Client Registration

Client Full Name:			Client Date of Birth
Referring Physician:			Today's Date:
Age:	Grade:	School Name:	

Parent/ Guardian Information:

Legal Guardian Name:			Relationship:
Street Address:			SS#:
City:	State:	Zip Code:	**Best Daytime # ( )**
Home Phone # ( )		Cell # ( )	
Email Address: May we contact you by email: yes_____ No_____		How did you hear about us:	
Other Parent/Guardian name:		**Phone # ( )** **Work_____ Cell_____ Home_____**	

Primary Insurance Information:

Policy Holder Name:		Insured Date of Birth:	
Relationship to Client:		Insurance Effective Date:	
Insured SS#:		Insurance Name:	
Contract/ Policy ID#:			Group#:
Employer Name of Insured:			
Do you have a secondary insurance plan you wish for us to file: ( ) yes ( ) no			

Secondary Insurance Information:

Policy Holder Name:		Insured Date of Birth:	
Relationship to Client:		Insurance Effective Date:	
Insured SS#:		Insurance Name:	
Contract/ Policy ID#:			Group#:

I authorize payment of medical benefits from the insurance carrier to Pediatric Therapy Link of North Alabama, LLC for services performed.

Signature: _____Date:_____

Emergency Contact Information:

Name:	Phone # ( )	Relationship:

Medical History:

Diagnosis:	
Current Medications:	
Allergies: Food & Drug	

I acknowledge that all information is accurate. The above information is confidential and will not be released without written consent. I understand the privacy policies of Pediatric Therapy Link of North Alabama, LLC

Signature: _____Date: _____

Revised: July 2013