Dr. Office/Clinic Name:		Location (city,state):
Primary Care Provider (Physician):		Phone : Fax:

CLIENT INFORMATION

Child's last name: First: Middle:			Medical Diagnosis: Yes ☐ No ☐	If Yes please list Medical Diagnosis:
Sex: M ☐ F ☐	Birth date: / /	Age:	Caregivers:	Relationship to Child:
Street Address:		City:		Zip Code:
Cell Phone:	Home Phone:		Primary Concerns:	
Occupation:	Employer:			Employer phone no.: ( )

INSURANCE INFORMATION

Policy Holder:	Birth date: / /	Address (if different):	Home phone : ( )
Occupation:	Employer:	Employer address:	Employer phone: ( )
Is child covered by insurance? ☐ Yes ☐ No			
Primary Insurance Carrier:	Birth date:	Group no.:	Policy no.:
Client's relationship to subscriber: ☐ Self ☐ Child ☐ Other			
Name of secondary insurance (if applicable):		Group no.:	Policy no.:
Client's relationship to subscriber: ☐ Self ☐ Child ☐ Other			
Referred to clinic by (please circle one): Dr. Friend Website Yellow Pages School Clinic Other:			
Other services child receives:			

IN CASE OF EMERGENCY

Relationship to patient:	Home phone no.:	Work phone no.:
	( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Therapy Junction, INC. I understand that I am financially responsible for any balance. I also authorize Therapy Junction or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*