

# Therapy House

(262)619-3265

700 Villa Street - Racine, WI 53403

FAX (262)619-3263

## **Child/Adolescent Registration Information**

**Patient Name:**(M / F) \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ May We Call At Work? Yes \_\_\_\_\_ No \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ May We Call At Work? Yes \_\_\_\_\_ No \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ ID/SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Benefits: \_\_\_\_\_

Co-Pays: \_\_\_\_\_ Deductibles: \_\_\_\_\_

Claims Address: \_\_\_\_\_

**Managed Care Company:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Precert Required? Yes / No Authorization #: \_\_\_\_\_

Number/Dates of visits Auth'ed: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group#: \_\_\_\_\_