Child Registration Form

Dawn Huebner, PhD

Date _____ **Person Completing Form** _____

Client's Name _____ **DOB** _____

Address_____ **Home Phone** _____

_____ **Mother's Cell** _____

_____ **Father's Cell** _____

Mother's Name _____ **Step Parent/Partner** _____

Address (if different) _____

_____ **Employer** _____

Home Phone _____ **Work Phone** _____

Father's Name _____ **Step Parent/Partner** _____

Address (if different) _____

_____ **Employer** _____

Home Phone _____ **Work Phone** _____

Primary Care Provider_____

PCP Address _____

_____ **PCP Phone** _____

<u>Insurance</u> Please note: I am not an in-network provider, but sometimes need to be in touch with insurance companies to help you sort out issues related to authorizations and claims.

Name of Company_____

ID/Certificate # _____ **Group#** _____

Subscriber _____ **Subscriber DOB**_____

Info regarding Mental Health Benefit _____

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Medical/Health Issues _____

_____

Medication (names and dosages) _____

_____

Previous/Current Therapies (Psychological, Psychiatric, OT, etc.) _____

_____

_____ **Date of Last Physical** _____

Names and Ages of Siblings _____

_____

Names and Ages of Others in Household _____

_____

Name of School _____ **Grade** _____

Name of Teacher _____ **Phone Number** _____

504, IEP, or Other Services _____

Please briefly summarize (we will discuss in more detail)

1. Current Symptoms/Concerns Prompting Therapy _____

_____

_____

_____

2. Goals For Therapy _____

_____

_____

_____