Office use only
Reg/final 2 tx pd:
Date: $
Dates used:
TL pd/date:
Initial paymnt pd:
Date: $
Refunds:

Development is CHILD'S PLAY!

AN EVALUATION AND TREATMENT CLINIC FOR CHILDREN NEEDING EXTRA HELP

Teri Wiss, M.A., O.T.R./L
Director

Registration Form for Infant Screening

Client's name: _____ Date of Birth: _____Date:_____

Parents: _____

Address: _____ City: _____ Zip: _____

Phone numbers: Home: _____ Other: _____

Mother Work: _____ Father Work: _____

Mother Cell: _____ Father Cell: _____

Please note with a * which phone number you prefer us to call **first**

In case of emergency, contact (name and number, relation to child): _____

_____

Does the client have any allergies:

Does the client have any physical condition/precautions or limitation that should be known (seizures, heart problems, asthma, muscle/bone disorder):

Professionals involved in the care/development of the client (physicians, psychologists, therapists, agencies):

Any diagnosis the client may have (or list "none"):

Any current medication (list name and reason for each medication):

Primary concerns for the client:

1.

2.

3.

Individual responsible for payment: _____

Employer: _____

Work Phone and Address: _____

Insurance: _____