|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Registration Form*** | | | | Anticipated Start Date: | | | | |
| Childs Name: Last First Middle | | | | | Nickname | | | Birth Date |
| Parent/Guardian Name | Home Number  ( ) | | | Cell Number  ( ) | | | Email Address | |
| Street Address Apt # City Zip Code | | | | | | | | |
| Employer | | Work Address | | | | | Work Number  ( ) | |
| Parent/Guardian Name | Home Number  ( ) | | | Cell Number  ( ) | | | Email Address | |
| Street Address Apt # City Zip Code | | | | | | | | |
| Employer | | Work Address | | | | | Work Number  ( ) | |
| **Childs Health Information** | | | | | | | | |
| Date of Childs last physical Exam: | | | Is your Child up to date on vaccinations? If not, please explain. | | | Does your child have any Allergy (including drug reaction)? | | |
| Childs Primary Physician:  Practice :  Physician: | | | Phone Number  ( )  Fax Number / Email | | | Address | | |
| Specialty Physician:  Type:  Practice :  Physician: | | | Phone Number  ( )  Fax Number / Email | | | Address | | |
| Specialty Physician:  Type:  Practice :  Physician: | | | Phone Number  ( )  Fax Number / Email | | | Address | | |



|  |  |
| --- | --- |
| Has your child been diagnosed? If yes, what is the diagnosis and by whom? | |
| Has your child received and/or is receiving any services, therapies or treatments? Please specify: | |
| Is there any service, therapy or treatment that you think your child needs or would benefit from? | |
| Does your child have any other medical condition we should be aware of? | |
| **Medical Insurance Information** | |
| Primary Insurance Company Name | Policy Number |
| Policy Holder Name | Policy Holder Birthdate |
| Secondary Insurance Company Name | Policy Number |
| Policy Holder Name | Policy Holder Birthdate |
|  | |
| What hours would you like to enroll your child at our center? | |
| How did you hear about us? | |
| Comments: | |

\*Please provide a copy of both sides of insurance cards and of diagnosis/prescription

We authorize The Puzzle Place (and its staff) to speak to the healthcare professionals listed above in reference to our child. Initial \_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for applying to The Puzzle Place!*

*We hope we can assist you and look forward to a continued relationship.*

*Have a wonderful day!*