WHS CHILDREN'S THERAPY CENTER
Registration Sheet

*****Please review and change or add any information that is incorrect or missing.*****

PATIENT DATA				
LAST NAME	**FIRST NAME and MI**	**Nickname NAME**		
SOCIAL SECURITY NUMBER	**PHONE # Home; Work: Cell:**	**BIRTHDATE**	**SEX M**	
STREET		**CITY, STATE, ZIP**		
RESIDENCE (COUNTY, CITY, TWP OR BOROUGH)		**PLACE OF BIRTH**		
SCHOOL/School District	**Present GRADE?**	**Email Address:**		
Diagnosis (if known)		**Having any pain ? ___Yes ____ No**		

RELATIVE'S CONTACT DATA		
MOTHER'S FULL NAME	**MOTHER'S ADDRESS**	**MOTHER'S PHONE Home- Work- Cell-**
FATHER'S FULL NAME	**FATHER'S ADDRESS __ SAME __**	**FATHER'S PHONE Home- Work- Cell-**
EMERGENCY CONTACT PERSON 1	**RELATION TO CHILD**	**CONTACT'S PHONE**
EMERGENCY CONTACT PERSON 2	**RELATION TO CHILD**	**CONTACT'S PHONE**
PERSON(S) TO WHOM CHILD MAY BE RELEASED	**NAME/ADDRESS:**	**PHONE:**
PERSON(S) TO WHOM CHILD MAY BE RELEASED	**NAME/ADDRESS:**	**PHONE:**

Guarantor Information

The Guarantor is the person with whom the insurance policy is held. (i.e. mother, father or guardian) An employer often provides this policy. If the patient has Medical Assistance as a primary insurance please provide information below for either parent/guardian. Carefully check to make sure this information is accurate as you are financially responsible for misinformation.

	GUARANTOR DATA		
GUARANTOR NAME	**BIRTHDATE**		**GUARANTOR PHONE** **Home-** **Work-** **Cell -**
GUARANTOR SS#	**GUARANTOR ADDRESS**		
GUARANTOR EMPLOYER AND PHONE NUMBER	**GUARANTOR EMPLOYER'S ADDRESS**		**GUARANTOR'S OCCUPATION**

		INSURANCE DATA		
1	**NAME OF INSURANCE**	**SUBSCRIBER**	**RELATION TO PT. (circle)** **MOTHER/FATHER/SELF**	**EFFECTIVE DATE** *** _____**
		I.D. NUMBER	**GROUP NUMBER**	
2	**NAME OF INSURANCE**	**SUBSCRIBER**	**RELATION TO PT.** **MOTHER / FATHER/ SELF**	**EFFECTIVE DATE** ***_____**
		I.D. NUMBER	**GROUP NUMBER**	
3	**NAME OF INSURANCE {Tertiary_ Insurance}**	**SUBSCRIBER**	**RELATION TO PT.**	**EFFECTIVE DATE**
		I.D. NUMBER	**GROUP NUMBER**	

	VITAL DATA	

ALLERGIES - Please complete Current information: no allergies

Allergic to Medications:

Dietary:

Environmental:

Latex: ___ yes ___No

SPECIAL CONDITIONS: no remarkable conditions

MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION:
__ none ___ other:

MEDICATION:
no medication

ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD:

REFERRING PHYSICIAN AND PHONE NUMBER: See below

FAMILY PHYSICIAN AND PHONE NUMBER
King, Dr. Edwin 412-221-2121

PARENT/GUARDIAN SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE CONSENT

Obtaining Emergency Medical Care	**Administration of Minor First Aid Procedures**
X	**X**

The hospital has a policy for releasing information about a patient in the absence of a parent/guardian. You are asked to choose a password that is no more than 10 letters or numbers. As long as they know the password, we will share information with any caregiver that may bring your child for services. If the caregiver does not know the password we cannot share any information regarding your child with them. You can change your password at any time with the front office staff.

Password: new: _____ ☐ unchanged from last year

REVIEW:
I attest that I have reviewed the above information and it is correct. I understand that I am legally and financially responsible for inaccurate information. I understand that it is my responsibility to notify office staff regarding any changes in a timely manner.

_____ _____
(Signature Parent/Guardian) (Date)