Advance Therapy
Occupational, Physical, and
Speech Language Therapy for Children
"Helping children shine!"

REGISTRATION FORM 2016

PATIENT INFORMATION:

PATIENT NAME:_____ **MALE / FEMALE**

DOB:_____ SS#:_____

ADDRESS:_____

NAME OF PHYSICIAN SUPPORTING THIS RECOMMENDATION
(OR PRIMARY CARE PHYSICIAN):

NAME:_____

CLINIC:_____ PHONE:_____ FAX: _____

PARENTS/LEGAL GUARDIANS:

1. NAME/POLICY HOLDER:_____MARITAL STATUS: **M S D W**

DOB:_____SS#:_____RELATION TO PATIENT:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL:_____

EMAIL:_____

2. NAME:_____

RELATION TO PATIENT:_____

ADDRESS (If different from above): _____

HOME PHONE:_____WORK PHONE:_____CELL:_____

6776 Lake Drive, Suite 220 Lino Lakes, MN 55014 Phone: 651-784-7007 Fax: 651-784-7992
2555 County Road E East, Suite 102 White Bear Lake, MN 55110 Phone: TBD
www.AdvanceTherapy.org

PATIENT NAME:_____

INSURANCE

PRIMARY:_____ GROUP #:_____ ID #: _____

POLICY HOLDER:_____EMPLOYER:_____

DOB:_____SS#_____INSURANCE PHONE:_____

SECONDARY:_____ GROUP #: _____ ID#: _____

POLICY HOLDER:_____EMPLOYER:_____

DOB:_____SS#_____INSURANCE PHONE:_____

OTHER CONTACTS

Please list other individuals who are involved in this patient's care, with which you authorize Advance Therapy to discuss the patient's treatment. (Spouse, step parent, grandparent, personal care attendant)

NAME:_____ EMERGENCY CONTACT:YES_____NO_____

RELATION TO PATIENT:_____

PHONE #1:_____ PHONE #2:_____

NAME:_____ EMERGENCY CONTACT:YES_____NO_____

RELATION TO PATIENT:_____

PHONE #1:_____ PHONE #2:_____

AUTHORIZATIONS

I authorize Advance Therapy to provide information concerning the treatment plan of this patient listed above to insurance carriers, physicians, therapists and other personnel who are involved in the treatment and care of the patient. I authorize payment of any medical benefits to Advance Therapy. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit of copy of this to be used in place of the original.

SIGNATURE:_____DATE:_____
PARENT/LEGAL GUARDIAN OR SELF

THANK YOU!

How did you hear about Advance Therapy?

Insurance Internet Search/Website Friend Physician School Phonebook

Other_____

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