genesis therapy center
Discovery…Recovery…Growth

CHILD CLIENT INFORMATION

Today's Date:

First Name | Middle Initial | Last Name

Address | City | State | Zip

Telephone Number | Birth Date

School Name | Grade

Primary Care Physician Name | Physician's Telephone Number

____ African-American
____ Hispanic
____ Caucasian
____ Other

PARENTS' INFORMATION

MOTHER

First Name MI Last Name

Address City State Zip

Home Telephone Number | Work Telephone Number

Status: _____ M (Married) _____ S (Single) _____ D (Divorced)

FATHER

First Name MI Last Name

Address City State Zip

Home Telephone Number | Work Telephone Number

Status: _____ M (Married) _____ S (Single) _____ D (Divorced)

INSURANCE FOR CHILD:

May we add you to our mailing list? Yes ( ) No ( ) E-mail address:_____

Name of insured

Address City State Zip

Insurance ID Number Group Number Insured's Date of Birth

Employer's Name

Is there a secondary insurance plan? ( ) Yes ( ) No If yes, please complete the following.

Name of insured

Address City State Zip

Insurance ID Number Insured's Date of Birth

Employer's Name

We will need a copy of your insurance card(s), please.

How were you referred to The Genesis Therapy Center? (Over)

PERSONS IN CHILD'S FAMILY:			
Name	Age	Relationship	Living with child?

Reason for seeking therapy now:

What would you like to see happen by bringing your child here?