Andrew DiFiore, LCSW – 970 Farmington Ave. Suite 305 – West Hartford, CT 06107 – 860-748-2331
Registration Form – Child/Adolescent

Date _____

Child's Name _____DOB _____ Age ____

Address _____ Town _____

State _____ Zip _____

School _____ Grade _____

How were you referred to this practice? _____

<u>Information regarding Mother</u>:

Name _____ DOB _____ Age____

Address, if different than above _____

Town _____ State _____ Zip _____

Primary Contact Phone _____ home work mobile (circle one)

Other Phone _____

<u>Information regarding Father</u>:

Name _____ DOB _____Age ____

Address, if different than above _____

Town _____ State _____ Zip _____

Primary Contact Phone _____ home work mobile (circle one)

Other Phone _____

Others living in the home:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ **Relationship** _____ **Age** _____

Name _____ **Relationship** _____ **Age** _____

Name _____ **Relationship** _____ **Age** _____

Primary Care Physician _____ **Phone** _____

Address _____ **Release Signed?** Y N

<u>Insurance Information: Primary</u>

Insured's Name _____ **DOB** _____

Relationship to Client: (circle one) **Self Spouse Child Other** _____

Insurance Company _____ **Company Phone** _____

Insured's ID Number _____ **Group/Policy Number** _____

<u>Insurance Information: Secondary</u>

Insured's Name _____ **DOB** _____

Relationship to Client: (circle one) **Self Spouse Child Other** _____

Insurance Company _____ **Company Phone** _____

Insured's ID Number _____ **Group/Policy Number** _____