PEDIATRIC NEUROPSYCHOLOGY
DIAGNOSTIC AND TREATMENT CENTER

"Commitment to Children, their Health, Development and Learning"

Evaluation and Brain Building Programs that Develop Potential and Success at Home, School and Beyond

REGISTRATION/INTAKE FORM

TODAY'S DATE:

PATIENT INFORMATION

Referred by: _____

First Name:	Home Telephone: ( )	
Last Name:	Birth Date: Age:	
Address:	Gender: Male _____ Female _____	
City:	State:	Zip Code:

RESPONSIBLE PARTY

Relationship to Patient:		
First Name:	Home Telephone: ( )	
Last Name:	Work Telephone: ( )	
Address:	Email Address:	
City:	State:	Zip Code:

PARENT INFORMATION

Mother's First Name - Date of Birth: _____

Mother's daytime/work phone: _____ Cell phone: _____

Email address: _____

Father's First Name and Date of Birth: _____

Father's daytime/work phone: _____ Cell phone: _____

Email address: _____

Marital Status of Parents: Married _____ Divorced** _____ Single _____

** Custody status and comments: _____

INSURANCE INFORMATION

Name of Policy Holder:	Relationship to Patient:
Name of Insurance Company:	Insurance Co. Phone#
Insurance ID#	Group #

I authorize the release of any information to my insurance company that may be necessary for the processing of my insurance claim(s):

Name of Insured (Print) _____ **Date:** _____

Signature of Insured: _____

Pediatric Neuropsychology Diagnostic and Treatment Center
16001 S. 108th Avenue, Suite B
Orland Park, IL 60467
708/403-9000