Innovative Therapy Services
Pediatric Speech-Language Services

Expect the Best in Learning Social Language Skills

1090 Homestead Rd.
Santa Clara, CA 95050
Phone/(408) 241-2229
Fax/(408) 241-3165

INITIAL REGISTRATION FORM for All's for 3 SOCIAL SKILLS PROGRAM

Section I: Patient Information Date_____

I am interested in registering my child for All for 3's Social Skills level_____

Child's Name: _____ Prefer to be called:
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact parents:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____

Name of School_____ City/State_____ ☐ FT ☐ PT
Whom may we thank for referring you? _____

Section II Responsible Party

Parent(s)/Legal Guardian(s):

Relationship to Patient: ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Parent #2:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Other Responsible Party:
Name: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone: _____ Pager: _____
Email: _____
Additional Contact Information: _____
_____

Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

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Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Doctor's Information
Doctor's Name: _____
Doctor's Address: _____
Doctor's Office Phone: _____ Doctor's Emergency Phone: _____
Medical Insurer/Health Plan: _____ Policy #: _____
Allergies to Medications: _____
Allergies (Other): _____
If applicable, please note the conditions for which the child is currently receiving treatment:
_____
Note any other significant medical information:
_____
_____

Parent signature: _____ Date: _____