6 Edwin Street, Morgantown, WV 26501
304-292-0173 Phone | 304-292-0174 Fax
PlayWorkscdc.com

CLIENT INFORMATION/REGISTRATION FORM

Date: ______________

Last Name: ____________________________ First Name: ____________________ MI: ___

Client Social Security Number: _________________________

Street Address: ____

City, State Zip: ____

Client Date of Birth: __________________________________ Sex: F____ M____

Home Phone: _____________________ Cell: ____________________ Work: ____________________

E-mail Address: www:____

Which phone number is best to reach you: _________________________________

RESPONSIBLE PARTY

Mother's Name: ____ Mother's DOB: _________________

Mother's SSN#:____

Father's Name : ____ Father's DOB: __________________

Father's SSN#:____

Street Address (if different from above): ____

City, State, Zip: ____

Additional Caregiver Name (if applicable): __________________________ Telephone: _________________

INSURANCE

Referring Physician: ___________________________ Diagnosis: _____________________________

Has the Client received any therapies within the past 6 months? _________

Primary Insurance Provider: ____

Provider telephone number: ____

ID Number: _________________________________ Plan Number: __________________

Member Name: _______________________________________

Secondary Insurance Provider if applicable: ____

ID Number: _________________________________ Plan Number: _____________________

EMERGENCY CONTACT NAME: ____

RELATIONSHIP TO CLIENT _______________________ **PHONE** ___________________________

When you present for your evaluation, you must have all insurance cards and a script from your physician. Thank you.