SUSAN L. COHN AND ASSOCIATES - 710 NW JUNIPER ST STE 108 ISSAQUAH, WA 98027
PHONE (425) 392-4965 FAX (425) 391-2555
www.susancohnandassociates.com

REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Name:	❑ F / ❑ M	Patient's Birth date: / /

RESPONSIBLE / INSURED PARTY INFORMATION

Parent / Legal Guardian's name:	❑ Mr. ❑ Miss ❑ Ms ❑ Mrs.	**Birth Date** / / Single / Mar / Div / Sep / Widow
Street address: ***(PLEASE PRINT CLEARLY)***		Home phone no.: ( )
City:	State:	Zip:	Cell phone no.: ( )
E-mail address:		Employer phone no: ( )
Name of Employer:		

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE THERAPIST.)

Is this patient covered by insurance?	❑ Yes	❑ No	**Insurance Claims Dept Phone no.:** ( )		
Please indicate primary insurance	❑ Blue Cross	❑ Blue Shield/Uniform	❑ First Choice	❑ United Healthcare	❑ Aetna
❑ DSHS	❑ Other	❑ DDD (please list case worker & phone #)			

Group no.:	**Policy no.:** ***(This may be different than Social Security no.)***	**Subscriber's Birth Date:**

Insurance Address:					
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Subscriber's name:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

OTHER PARENT INFORMATION

Other Parent name:		**Birth Date** / /
Address (if different than above):		
Home phone no.: ( )	Cell phone no.: ( )	Employer phone no.: ( )
E-mail address:	Employer:	

There may be instances where we need to leave a message for you via your preferred method of contact (see below). Please initial in this box if we have your permission to leave a message if we are unable to reach you. Thank you.

Preferred Method of Contact for billing: ❑ Cell phone ❑ Home phone ❑ E-mail

Preferred Method of Contact for appointments/other: ❑ Cell phone ❑ Home phone ❑ E-mail ❑ Employer

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that any unpaid balance over 60 days is subject to a 1% finance charge and possible collection action. I also authorize Susan L. Cohn Associates or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

I acknowledge that I have received a copy of Susan L. Cohn and Associates **Notice of Privacy Practices**

Patient/Guardian signature *Date*

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HEALTH HISTORY QUESTIONNAIRE

(Please Print Clearly)

PATIENT INFORMATION

Patient's Name:	
Primary or Referring Doctor's Full Name:	
Phone Number for Primary / Referring Doctor:	
Date of Last Exam: (mm/yyyy)	
Did you receive a prescription or referral from the Referring Doctor? If yes, please provide this with intake form prior to first appointment. Thank you!	❑ Yes ❑ No
Please list the Diagnosis Code(s) or description given by Primary / Referring Doctor:	

PATIENT HEALTH INFORMATION

Please list any childhood illness or other pertinent medical conditions: such as vision; hearing; seizures; anxiety; ADD etc.

Please list any food allergies that your child has, please list severity as well:

CURRENT MEDICATIONS:

Please list all medicines that your child is currently taking (include prescribed drugs, over-the-counter drugs, vitamins, inhalers, etc.)

Name of Drug/purpose:	Strength:	Frequency taken:	Date Started:
Name of Drug/purpose:	**Strength:**	**Frequency taken:**	**Date Started:**

OTHER THERAPY INFORMATION

If your child is receiving or may receive additional therapies, such as Occupational Therapy or Physical Therapy, ABA, Counseling or Tutoring, etc. please complete this section ~

Type of Therapy:		Provider / Clinic Name:	
Provider's Address:			
Provider Phone No and / or E-mail Address:			
Type of Therapy:		Provider / Clinic Name:	
Provider's Address:			
Provider Phone No. and / or E-mail Address:			

SCHOOL INFORMATION

If your child is school age please list the school that he/she attends:	Grade Level:

If your child is receiving or is eligible to receive any special services through his/her school please indicate what type of services these are: (For example: IEP; 504)