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Dreamworks
Children's Therapy Network

REGISTRATION FORM

Please complete the following information for our records. This information is confidential.

Child's Name:	DOB:	□ Male □ Female
Ethnic Group:	Services of interest: □ Occupational Therapy □ Physical Therapy	

Describe your primary areas of concern:

PARENT/GUARDIAN INFORMATION

Father's Name:		Mother's Name:	
Street Address:		Street Address:	
City:	State & Zip:	City:	State & Zip:
Father's Phone:		Mother's Phone (mom):	
Father's E-mail address:		Mother's E-mail Address:	

Child lives with: □ Birth Parents □ One Parent (which one? _____)
□ Parent & Step-Parent □ Foster Parents □ Adoptive Parents □ Other:

OTHERS IN HOUSEHOLD

Name:	Relationship:	DOB:

Emergency Contact:	Relationship:	Contact Number:

REFERRING PHYSICIAN INFORMATION

Referring Physician:	Physician's Phone:
Physician's Mailing Address:	Reason for Referral:

PRIMARY CARE PHYSICIAN *(your child's regular doctor)*

Primary Care Physician:	Physician's Phone:
Physician's Mailing Address:	Date of last visit: Are immunizations up to date? □ Yes □ No

DEVELOPMENTAL HISTORY

Was your pregnancy full-term? □ Yes □ No
Was there anything unusual about the pregnancy or birth? □ Yes □ No
If yes, please describe:

Please tell the approximate age your child achieved the following developmental milestones:
_____ Sat alone _____Rolled over _____ Crawled _____ Walked
_____ Babbled _____Said first words _____ Put two words together
_____ Spoke in short sentences _____Toilet trained _____Grasped crayon/pencil

Please indicate your child's current capabilities (please check all that apply):

Mobility:	Drinking:	Eating:	Dressing:
□ dependent	□ dependent	□ dependent	□ dependent
□ crawls	□ drinks from bottle	□ finger feeds	□ needs some help
□ stands independently	□ drinks from sippy cup	□ eats with utensils	□ dresses independently
□ walks independently	□ only from open cup	□ picky eater/limited diet	□ manipulates fasteners

If your child is a picky eater, please describe:

MEDICAL HISTORY

Diagnoses: _____ Date of onset: _____

_____ Date of onset: _____

Current Medications & Dosages:	Is your child currently (or recently) under a physician's care? □ Yes □ No If yes, why?

Is your child currently receiving therapy services (include school-based services)? □ Yes □ No

Type	Frequency	Location/School Name	Therapist's Name	Phone/E-mail

Has your child been assigned a service coordinator (through "Babies Can't Wait") ? □ Yes □ No
If yes, please provide service coordinator's name and phone number.
Name: Phone Number:

Does your child have an □ IEP or □ IFSP? If yes, please submit copies with completed registration form. ALSO NOTE: If your child is involved with "Babies Can't Wait," we must be included on his/her IFSP before services begin. Contact your child's service coordinator for instruction &additional information.

Does your child have a history of any of the following? Check all those that apply:

□ Adenoidectomy	□ Allergies: _____	
□ Asthma	□ Birth Defects	□ Ear Infections
□ Ear Tubes	□ Encephalitis	□ Feeding Difficulties
□ Head Injury	□ Hearing Impairment	□ Heart Condition
□ Hydrocephalus/Shunts	□ Meningitis	□ Scoliosis
□ Sinusitis	□ Sleeping Difficulties	□ Thumb/finger sucking habit
□ Tonsillectomy	□ Tonsillitis	□ Visual Impairment

□ Other: _____
□ Seizures/Epilepsy: If yes, are they controlled by medication? □ Yes □ No Date of last episode:

Has your child had any serious illnesses/injuries/surgeries? □ Yes □ No
If yes, please share date(s) & description(s):

Does your child:
□ Choke on food or liquids? □ Currently put toys/objects in his/her mouth?
□ Brush his/her teeth and/or allow brushing?

COMMUNICATION

Is there a language other than English spoken in the home? □ Yes □ No
If yes, which one? _____
Does the child speak the language? □ Yes □ No
Does the child understand the language? □ Yes □ No
Who speaks the language? _____
Which language does the child prefer to speak at home?

Your child currently communicates using:	Does your child:
□ Assistive technology	□ Repeat sounds, words or phrases over and over?
□ Sign-language	□ Understand what you are saying?
□ Sounds (vowels, grunting)	□ Retrieve/Point to common objects upon request (ball, cup, shoe)?
□ Words	□ Follow simple directions ("Shut the door" or "Get your shoes")?
□ 2 to 4 word sentences	□ Respond correctly to yes/no questions?
□ Sentences longer than 4 words	□ Respond correctly to who/what/where/when/why questions?
□ Other:	

Do you feel your child has a speech problem? □ Yes □ No
If yes, please describe:

Has he/she ever had a speech evaluation/screening? □ Yes □ No
If yes, where & when?
What were you told?

Do you feel your child has a hearing problem? □ Yes □ No
If yes, please describe:

Has he/she ever had a hearing evaluation/screening? □ Yes □ No
If yes, where & when?
What were you told?

Is your child aware of, or frustrated by, any speech/language difficulties? □ Yes □ No
If yes, please describe:

BEHAVIORAL CHARACTERISTICS

□ Aggressive/Destructive □ Attentive/Cooperative □ Easily Distracted/Short Attention Span
□ Easily Frustrated □ Impulsive □ Inappropriate touching
□ Plays alone for reasonable length of time □ Poor eye contact
□ Self-abusive behavior □ Separation difficulties □ Withdrawn:
□ Stims – Describe:

Identify what you believe to be your child's greatest assets:

Do you have any specific areas of concern?

Please share with us any other information you feel would assist us in developing an appropriate treatment plan for your child:

INSURANCE INFORMATION

Please supply Dreamworks Children's Therapy Network with copies of all insurance cards (front & back)

Is the patient covered under (check all that apply):

□ Primary Insurance □ Secondary Insurance □ Medicaid #: □ Amerigroup □ Wellcare

PRIMARY INSURANCE INFORMATION

Subscriber:	DOB:	SSN:	Relationship to patient:
Employer:	Insurance Company:		Phone Number:
Policy Number:	Group Number:	□ HMO □ PPO □ POS	
Phone: Fax:	Claims Address:		
City:	State:	Zip:	

SECONDARY INSURANCE INFORMATION

Subscriber:	DOB:	SSN:	Relationship to patient:
Employer:	Insurance Company:		Phone Number:
Policy Number:	Group Number:	□ HMO □ PPO □ POS	
Phone: Fax:	Claims Address:		
City:	State:	Zip:	

GEORGIA MEDICAID INFORMATION

Date Medicaid Was Effective:	Patient's Medicaid #:	Medicaid provided by: □ Social Security □ Deeming Waiver □ Peachcare for Kids

ASSIGNMENT OF BENEFITS

I authorize and direct my insurance company to pay directly to Dreamworks Children's Therapy Network any insurance benefit otherwise payable to me. I further authorize and direct Dreamworks Children's Therapy Network to release all relevant information with respect to me or any of my dependents, which may have bearing on the benefits payable under the above stated insurance plan or any other plan providing benefits or services.

_____ _____

Signature of Parent/Legal Guardian Date

GUARANTEE OF PAYMENT FOR SERVICES RENDERED

I, _____, certify that I am the parent/legal guardian of _____ (child's name), and that I am responsible for paying all medical bills for _____ (child's name).

I understand and agree that I am the guarantor of payment for services rendered by Dreamworks Children's Therapy Network. If my child receives Medicaid benefits, or is covered by any other private insurance company (e.g. BlueCross BlueShield, United Healthcare, etc.), I understand that I will pay for any services rendered that are not covered by their insurance provider.

_____ _____

Signature of Parent/Legal Guardian Date