Child Registration Form

Child's Name: _____ Date: _____

Gender: M F Date of Birth: _____ Age: _____

Parent/Guardian 1 Name: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian 1 Employer: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

Parent/Guardian 2 Name: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian 2 Employer: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

Child's Pediatrician _____ Phone _____
I have discussed my concerns with my pediatrician: Yes No
Who referred you to Laughing Giraffe Therapy? _____
Would you like to receive a copy of a monthly summarized Superbill? Yes No

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CLINIC USE ONLY

Diagnostic Codes:_____