Easter Seals DuPage and the Fox Valley Region

Client Registration Form

DATE: _____

CLIENT INFORMATION

(PLEASE PRINT)

Legal Name: First _____ MI _____ Last Name _____

Preferred Name (Nickname): _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____ Physical Address (if different than mailing): _____

City/State/ZIP: _____ City/State/ZIP: _____

County: _____ County: _____

Township: _____ Township: _____

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian One:

☐ Mother ☐ Father ☐ Other _____

☐ Preferred Contact ☐ Child lives with this person

☐ Legal Guardian

Full Name: _____

Address: _____

City/State/ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

☐ Do not send Marketing or Development Emails

Parenting Status: ☐ Natural ☐ Adoptive ☐ Foster

Are you a legal guardian? ☐ Yes ☐ No ☐ Other _____

Parent/Legal Guardian Two:

☐ Mother ☐ Father ☐ Other _____

☐ Preferred Contact ☐ Child lives with this person

☐ Legal Guardian

Full Name: _____

Address: _____

City/State/ZIP: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

☐ Do not send Marketing or Development Emails

Parenting Status: ☐ Natural ☐ Adoptive ☐ Foster

Are you a legal guardian? ☐ Yes ☐ No ☐ Other _____

EMERGENCY CONTACT (PLEASE LIST A CONTACT OTHER THAN IMMEDIATE FAMILY MEMBERS)

Full Name: _____ Home Phone #: _____

Relationship to Client: _____ Cell Phone #: _____

ADDITIONAL CONTACTS

Primary Care Physician

Name: _____ Practice Name: _____

Address: _____ Office Phone: _____

City/State/ZIP: _____ Fax #: _____

INSURANCE INFORMATION

Primary Insurance Information:

Name of Insured: _____

Insurance Company Name: _____

Insured/Subscriber Information:

Group ID #: _____

Insured ID #: _____

Contact Phone #: _____

Is a referral/authorization required? Yes ☐ (If Yes, attach copy.) No ☐

Secondary Insurance Information:

Name of Insured: _____

Insurance Company Name: _____

Insured/Subscriber Information:

Group ID #: _____

Insured ID #: _____

Contact Phone #: _____

Is referral/authorization required? Yes ☐ (If Yes, attach copy.) No ☐

REQUESTED SERVICES

☐ Physical Therapy ☐ Speech/Language Therapy ☐ Occupational Therapy ☐ Assistive Technology

☐ Nutrition ☐ Audiology ☐ Other Services: _____

How did you hear about us?

☐ Physician Name: _____ ☐ Friend ☐ Insurance Company

☐ Advertisement ☐ Internet ☐ Other _____

ADDITIONAL INFORMATION

Providing this information is optional, but it is essential in helping us apply for grants to fund our services for families who cannot afford it. This information is confidential and will not be disclosed on an individual basis, but will only be used to provide consolidated information to organizations that can provide funding for our services.

Ethnicity: ☐ White, non-Hispanic ☐ Hispanic ☐ American Indian/Alaskan Native

☐ Black, non-Hispanic ☐ Asian/Pacific Islander ☐ Other: _____

Do you speak English? Yes ☐ No ☐ If No, which language do you speak? _____

Household Income: ☐ Less than $10,000 ☐ $30,000 - $40,000 ☐ $60,000 - $70,000 ☐ $90,000 - $100,000

☐ $10,000 - $20,000 ☐ $40,000 - $50,000 ☐ $70,000 - $80,000 ☐ Over $100,000

☐ $20,000 - $30,000 ☐ $50,000 - $60,000 ☐ $80,000 - $90,000

Number of People in Household: _____ Female Head of Household: ☐ Yes ☐ No