

Pathways to Success

Application for Services

Name (your child) _____

Home Address _____

City _____ Zip Code _____

Home Phone _____ Date of Birth _____

Mother's Name _____ Phone _____

Mother's Address _____

Father's Name _____ Phone _____

Father's Address _____

Insurance is in the name of (mother or father) _____

Employer of Insured _____

Insurance Company _____ Group Name/# _____

Insurance Phone _____ Contract # _____

Insurance Claims Address _____

In case of an emergency, contact _____

Emergency contact's relationship to client (if other than parent) _____

Emergency contact home phone (if other than parent) _____

Emergency contact alternate phone (work or cel) _____

Client's current medications (and dosages, if known) _____

Describe client medical problems (including pain) _____

Referred by _____ May I thank the referral source? Yes No

Would you like to be added to paths2success.com email list for future informational mailings?
(Your information will not be shared with any other source.) Yes No

By signing below, I/we consent to the treatment of our daughter/son.

Parent Signature

Date