



Avon Therapeutic Center
for Children, LLC

Patient Registration Form

(Please print, complete, and mail / fax this form to Avon Therapeutic Center for Children, LLC)

Today's date: _____ / _____ / _____

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ / _____ / _____ Age: _____ Gender: M / F

Street Address: _____

City: _____ State: _____ Zip: _____

Country: _____

Tel: _____ Email: _____

PARENTS INFORMATION

Father's Name: _____ Occupation: _____

Address: _____

Tel. _____

Mother's Name: _____ Occupation: _____

Address: _____

Tel. _____

EMERGENCY CONTACT (OTHER THAN PARENT)

Name: _____ Relation to Patient: _____

Address: _____

Contact Tel. No. _____

PATIENT INFORMATION

Diagnosis / Date Diagnosed: _____

Medications: _____

Allergies:

Food: _____

Medications: _____

Environmental: _____

Chemical: _____

Primary Care Physician: _____

Address: _____

Tel. _____