

ADMISSION APPLICATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

E-MAIL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

INSURANCE PROVIDER _____ PHONE _____

ID # _____ GROUP # _____

NAME OF PRIMARY INSURED _____

EMERGENCY CONTACT _____

RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____

PHYSICIAN _____ PHONE _____

THERAPIST _____ PHONE _____

HOW DID YOU FIND US? _____

I am applying for admission to Clementine. I understand that admission is subject to submission and review of my Intake Questionnaire, Parent Intake Questionnaire, and Educational Intake Form. All will be reviewed by members of the clinical team of Clementine.