Vanguard Center for Neurological Health Client Registration Form

Client Information:

Client Name: _____

Address: _____

Date of Birth: _____ Gender: ◯ Male ◯ Female

Preferred Language: _____

Current Diagnosis: _____

Date of Diagnosis: _____ Diagnosing Physician: _____

Parent/Guardian Information:

Mother/Guardian I: _____

Address: _____

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Preferred Language: _____

Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Provider Phone Number: _____
(back of insurance card)

◯ Primary Coverage ◯ Secondary Coverage

Father/Guardian II: _____

Address: _____

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____ Employer: _____

Insurance Carrier _____

Policy Number: _____ Group Number: _____

Provider Phone Number: _____
(back of insurance card)

◯ Primary Coverage ◯ Secondary Coverage

Other Insurance Coverage:

Policy Holder: _____

Insurance Carrier: _____

Insurance Policy No.: _____

Insurance Group No.: _____

Provider Phone Number: _____
(back of insurance card)

◯ Primary Coverage ◯ Secondary Coverage

Emergency Contact Information

Name: _____ Phone Number: _____

Relationship to Child: _____

How did you hear about us? _____