



Apple Tree Therapy, LLC

Jackie Brown, DrOT, OTR/L
Pediatric Occupational Therapist
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Phone: 360-286-2351

CLIENT REGISTRATION

Client Information

Client Legal First Name: _____ Middle Initial: _____ Last Name: _____

Client Preferred Name: _____ D.O.B: _____ Pediatrician: _____

Gender Identity: Female Male Non-binary Other: _____

Preferred Pronouns: she/her he/him they/them Other: _____

Relationship to Child (please check one):

Biological Adoptive Step Foster Other

Legal Guardian A: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Child Resides with: _____

Sibling(s) Name/Age: _____

Relationship to Child (please check one):

Biological Adoptive Step Foster Other

Legal Guardian B: _____

Address: same as Legal Guardian A

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Employer: _____

Custody Status: Together/Joint Mother Father Other: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation to Client/Child: _____ Phone: _____

**If primary person bringing client to therapy is not listed above, please list name and contact number of that person below:*

Name: _____ Phone: _____

How did you hear about Apple Tree Therapy, LLC? _____

Insurance Information

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Phone: _____

Name of Guarantor: _____

Guarantor Date of Birth: _____

Secondary Insurance: _____

Policy Number: _____

Group Number: _____

Phone: _____

Name of Guarantor: _____

Guarantor Date of Birth: _____