1311 Mangrove Ave. Ste. C
Chico, CA 95926
Tel: (530) 345-0678
Fax: (530) 345-0668

LEAP ENROLLMENT FORM

CLIENT INFORMATION

NAME: LAST	FIRST	MI	D.O.B. Age:	☐ MALE ☐ FEMALE	
STREET ADDRESS	APT#	CITY	STATE	ZIP	HOME PHONE # ( )
HOW DID YOU HEAR ABOUT OUR SERVICES? **Please check all that apply.** ☐ doctor ☐ billboard ☐ radio ☐ newspaper ☐ television ☐ friend ☐ relative ☐ poster ☐ other (specify)	FAMILY PHYSICIAN ADDRESS	CITY	STATE	ZIP	
TYPE OF INSURANCE: ☐ MEDI·CAL ☐ HEALTHY FAMILIES ☐ OTHER					SS.#
HAVE YOU OR ANYONE IN YOUR FAMILY PARTICIPATED IN OUR PROGRAM BEFORE? ☐ NO ☐ YES CLIENT'S NAME:		WHEN?			

PARENT INFORMATION

MOTHER'S NAME:	ADDRESS	CITY/STATE/ZIP	HOME PHONE#
OCCUPATION:	EMPLOYER:		WORK PHONE #
FATHER'S NAME:	ADDRESS	CITY/STATE/ZIP	HOME PHONE #
OCCUPATION:	EMPLOYER:		WORK PHONE #

EMERGENCY CONTACT	PHONE	RELATIONSHIP

INSURANCE INFORMATION

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT				
PRIMARY INSURANCE COMPANY	SUBSCRIBER'S NAME	BIRTH DATE	ID#	GROUP #
INSURANCE CO. ADDRESS				
CITY	STATE	ZIP	PHONE #	
SECONDARY INSURANCE COMPANY	SUBSCRIBER'S NAME	BIRTH DATE	ID #	GROUP #
INSURANCE CO. ADDRESS				
CITY	STATE	ZIP	PHONE #	

Insurance authorization and assignment
I herby authorize payment from my insurance company for services rendered to be sent directly to OPT for fit kids. If payment is not made at time of service, I also authorize the release of medical information to my insurance company concerning my treatment. I understand that I am responsible for any amount not covered by insurance.

Signature of Parent or Guardian ____ Date____________________