



4566 Lawrenceville Hwy Suite 101 Lilburn GA 30047  
770-217-7563 office. 770-818-5753 fax

## GROUP REGISTRATION FORM

NAME: \_\_\_\_\_

PARENT/GUARDIAN NAME (IF APPLICABLE):

\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

CONTACT NUMBER: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

***PLEASE PROVIDE NAME AND CONTACT INFORMATION TO YOUR PRIMARY THERAPIST (IF APPLICABLE)***

PRIMARY THERAPIST CONTACT NAME AND NUMBER:

\_\_\_\_\_

PLEASE LIST THE NAME(S) OF THE GROUP YOU ARE INTERESTED IN ATTENDING:

\_\_\_\_\_

\_\_\_\_\_

**Please return this form via email/fax and you will be contacted by the group facilitator.**