Patient Intake Form

Child's Name: ____ Date: ____/____/____

Address: ____ Home Phone: ______________ Cell:_______________

City: ________________________ State: ________ Zip: ________ Email: ______________________________

Social Security Number: _______-______-_______ Date of Birth: ____/____/____ Gender: M F

Person to be notified in case of emergency: ____
(name) (phone number) (relationship)

Referring Physician: _______________________________ Primary Physician: __________________________________

Party Responsible for Payment: _______ Self _______ Personal Insurance _______ Medicaid

Insurance Information: (please note that it is your responsibility to provide accurate insurance information)

Primary: ____
(Policy Number) (Effective Date)

Secondary: ____
(Policy Number) (Effective Date)

I understand that billing of insurance companies is a courtesy, and that I am financially responsible for payment at the time services are rendered. If I do not provide the correct information required for billing, I agree to be personally responsible for all expenses associated with services rendered. Expenses may include interest charges, collection fees, and legal/court costs.

Medical History

Please mark this box if you have had any other Occupational Therapy or Physical Therapy services this year ☐

Hospitalizations Within Past 2 Years:____

Current List of Medications:____

Currently Being Treated or Under a Doctor's Care for the Management of: ________________________________

____

Check all That Apply: ___Hearing Impaired ___Wear Glasses/Contacts

Signature of parent/ Guardian: ____ Date______________________