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_____

Do you request that your treating therapist wear a mask at all times? ___ yes ___ no