DARLING Pediatric Therapies
1475 Holcomb Bridge Rd., Ste. #113, Roswell, GA 30076
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Patient Information Form

Therapist:_____

Date:_____

Patient Information

Patient Name	Date of Birth:	Sex: Male ☐ Female ☐	
Address:			
City:	State:	Zip:	Telephone #:
Guarantor Name:			
Address: (if different from above)			
Home Phone #:	Work Phone #:	Cell Phone #:	
Guarantor Date of Birth:		Sex: Male ☐ Female ☐	
Email Address:			
Diagnosis: (all that apply)			
Other Comments:			

Pediatrician Information

Pediatrician Name:	Name of Practice:		
Address:			
City:	State:	Zip:	Telephone #:
County:	FAX #:	Email Address:	

Primary Insurance

Please Copy both sides of your insurance card

Policy Holder:		Relationship to Patient:	
Date of Birth:	Policy Number:	Group Number:	
Insurance Company:	Type of Insurance: HMO ☐ PPO ☐ POS ☐ EPO ☐ Other ☐		Insurance Phone#:
Employer:		Employer Phone:	

Secondary Insurance

Please Copy both sides of your insurance card

Policy Holder:		Relationship to Patient:	
Date of Birth:	Policy Number:	Group Number:	
Insurance Company:	Type of Insurance: HMO ☐ PPO ☐ POS ☐ EPO ☐ Other ☐		Insurance Phone#:
Employer:		Employer Phone:	

Medicaid		Babies Can't Wait	
Medicaid Number:		County:	
Effective Date:		Cost Participation Amount:	
Type of Medicaid		Please provide a copy of your IFSP	

FAILURE to complete this form in its entirety will nullify any agreement allowing us to file your claims.
THIS WILL RESULT IN THE GUARANTOR BEARING ALL FINANCIAL RESPONSIBILITY FOR DIRECT PAYMENY OF ALL SERVICES RENDERED ON THIS ACCOUNT!

Background Information

Mother's Name: | Date of Birth:

Mother's Occupation:

Father's Name: | Date of Birth:

Father's Occupation:

Current Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Languages Spoken at Home: (Circle Primary)

Is Your Child Adopted?: YES ☐ NO ☐ | How many brothers & sisters are there? :

What are your goals and priorities in coming to Therapy? :

Has your child previously received therapy services? : YES ☐ NO ☐ Type of Therapy Received:

If YES, where and when did they receive therapy? :

Medical History

At how many weeks was your child born? : | Birth weight? :

Were there any complications during pregnancy or delivery? : YES ☐ NO ☐ Please describe :

Was your child hospitalized after birth? : YES ☐ NO ☐

Does your child have any other medical issues? YES ☐ NO ☐ List Current Prescribed Medications :

Does your child have any known allergies or food restrictions? YES ☐ NO ☐ Please describe :

Education Information

Is your child currently enrolled in school? YES ☐ NO ☐ | Where?

How many days per week does your child attend? | Does your child have a current Education Plan (IEP)? YES ☐ NO ☐

Does your child receive any services through the school? YES ☐ NO ☐ Please describe :