DARLING
Pediatric Therapies, Inc.
1475 Holcomb Bridge Rd., Ste. #113, Roswell, GA 30076
678-591-3542 Fax:770-234-6837
Email: DarlingOT@msn.com

Patient Information Form

Patient Information

Patient Name:	**Date of Birth:**	**Sex:** Male ☐ Female ☐	
Address:			
City:	**State:**	**Zip Code:**	**Primary Contact Phone:**
Primary Contact Email:			
Guarantor Name:			
Address: (if different from above)			
Cell Phone: (if different from above)			
Guarantor Date of Birth:		**Sex:** Male ☐ Female ☐	
Diagnosis: (all that apply)			
Other Comments:			

Pediatrician Information

Pediatrican Name:	**Name of Practice:**		
Address:			
City:	**State:**	**Zip:**	**Telephone:**
County	**Fax Number:**	**Email:**	

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:**		

GA 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)

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? :

Was 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?: | Current grade level:

How many days per week does your child attend? : | Does your child have a current Individual Education plan (IEP)?: Yes ☐ No ☐

Does your child receive any services through the school? : Yes ☐ No ☐ Please describe: