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

Patient Information Form

Email: DarlingOT@msn.com

	Patient Information										
Patient Name:	Date			ite of Birth	e of Birth:			Male		Female	•
Address:											
City:		State:	Zip Co	ode:	Primar	y Contact	t Phon	e:			
Primary Contact Email:											
Guarantor Name:											
Address: (if different from abo	ove)										
Cell Phone: (if different from a	above)										
Guarantor Date of Birth:							Sex:	Male		Female	<u>;</u>
Diagnosis: (all that apply)											
Other Comments:											
	P	Pediatrician	Inform	ation							
Pediatrican Name:			Na	me of Pra	ctice:						
Address:											
City:	State:			Zip:			Te	lephon	e:		
County											
County		Fax Number	1:			Email:					
County		rax Number nary Insurai		Please	e copy	Email: both side		our in	sura	ance ca	rd
Policy Holder:				Please			es of y		sura	ance ca	rd
		nary Insura		Please	Relati	both side	es of y		sura	ance ca	rd
Policy Holder:	Prim	nary Insura	нмо	PPO PO	Relati	both side	es of y Patie mber:				rd
Policy Holder: Date of Birth:	Prim	umber:	нмо	PPO PO	Relati	both side ionship to iroup Nur Other	es of y Patie mber:	nt:			rd
Policy Holder: Date of Birth: Insurance Company:	Prim Policy N	umber:	HMO	PPO PO	Relati S EPO yer Pho	both side ionship to iroup Nur Other	es of y Patie mber: Insu	nt: rance Pl	hon	e:	
Policy Holder: Date of Birth: Insurance Company:	Prim Policy N	umber: Type of Insurance	HMO	PPO PO	Relati	both side ionship to Group Nur Other	es of y Patie mber: Insur	nt: rance Pl	hon	e:	
Policy Holder: Date of Birth: Insurance Company: Employer:	Prim Policy N	Type of Insuran	HMO	PPO PO	Relati G S EPO yer Pho e copy Relati	both side ionship to Group Nur Other one:	es of yo Patie Insui es of yo Patie	nt: rance Pl	hon	e:	
Policy Holder: Date of Birth: Insurance Company: Employer: Policy Holder:	Policy N Secon	Type of Insuran	HMO ce:	PPO PO Emplor	Relati G S EPO yer Pho e copy Relati	both side ionship to Other one: both side ionship to Group Nur	es of your parties of your par	nt: rance Pl	hon	e: ance ca	
Policy Holder: Date of Birth: Insurance Company: Employer: Policy Holder: Date of Birth:	Policy N Secon	umber: Type of Insurant Indary Insurant umber: Type of	HMO ce:	PPO PO Emplo	Relati G S EPO yer Pho e copy Relati	other both side oroup Nur Other both side ionship to Group Nur	es of your parties of your par	nt: rance Pl your in: nt:	hon	e: ance ca	
Policy Holder: Date of Birth: Insurance Company: Employer: Policy Holder: Date of Birth: Insurance Company: Employer:	Policy N Secon	umber: Type of Insurant Indary Insurant umber: Type of	HMO ce:	PPO PO Emplo	Relati S EPO yer Pho Relati G S EPO	other both side onship to other one: both side onship to other Other other other	es of yo Patie es of yo Patie mber: es of yo Patie mber:	nt: rance Pl your in: nt:	sura	e: ance ca	
Policy Holder: Date of Birth: Insurance Company: Employer: Policy Holder: Date of Birth: Insurance Company: Employer:	Policy N Secon	umber: Type of Insurant Indary Insurant umber: Type of	HMO ce:	PPO PO Emplo	Relati G S EPO yer Pho Relati G S EPO yer Pho	other both side onship to other one: both side onship to other Other other other	es of yo Patie es of yo Patie mber: es of yo Patie mber:	rance Pl your in nt:	sura	e: ance ca	
Policy Holder: Date of Birth: Insurance Company: Employer: Policy Holder: Date of Birth: Insurance Company: Employer:	Policy N Secon	umber: Type of Insurant Indary Insurant umber: Type of	HMO ce:	PPO PO Employ Please PPO PO Employ County	Relati S EPO yer Pho Relati GS EPO yer Pho yer Pho	other both side onship to other one: both side onship to other Other other other	es of yo Patie Patie Patie Patie Patie Insui	rance Pl your in nt:	sura	e: ance ca	

	Backgrou	und Inform	nation					
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 P	rimary)							
How many brothers & sisters are the	re? :							
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 rece	eive therapy? :							
	Medica	l History						
At how many weeks was your child b				Birth weight?	:			
Was there any complications during pregnancy or delivery : Yes No Please describe:								
		П	Ш					
Was your child hospitalized after birt	h?: 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:								
	Educat	ion Inform	nation					
Is your child currently enrolled in sch	ool?: Yes No	Where?:			Current grade lev	el:		
How many days per week does your	child attend?:			your child ha		Yes	No	
			inaiv	idual Educatio	on plan (IEP)?:	Ш	Ц	
Does your child receive any services	through the school?	Yes No		se describe:				
			•					