"Now We're Talking"
Pediatric Therapy, Inc.

CLIENT INTAKE FORM

DATE OF REFERRAL: _____ TYPE OF REFERRAL: Speech Therapy__ Occupational Therapy__

CLIENT LAST NAME: _____FIRST NAME: _____MI: ____

ADDRESS: _____

PHONE NUMBER: _____CELL NUMBER: _____EMAIL: _____

DATE OF BIRTH: _____ SEX: M or F

PARENTS/GUARDIANS NAMES: _____

PHONE NUMBER: (if different)_____WORK PHONE: _____ EMAIL: _____

PHYSICIAN: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

PRIMARY DIAGNOSIS: _____

OTHER DIAGNOSIS/MEDICAL CONCERNS: _____

MEDICAID NUMBER: _____

NPI Number (for office use only): _____

INSURANCE COMPANY: _____PLAN: _____

GROUP NUMBER: _____SUBSCRIBER NUMBER: _____

2 DIGIT NUMBER NEXT TO PATIENTS NAME: _____

BILLING ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

INSURED EMPLOYER'S NAME OR SCHOOL NAME: _____

PLACE OF THERAPY: CIRCLE ONE HOME DAYCARE PRESCHOOL CLINIC

NAME & ADDRESS OF HOME/DAYCARE/PRESCHOOL_____

DAYCARE/PRESCHOOL: PHONE: _____CONTACT PERSON: _____

BEST DAYS/TIMES TO BE SEEN/DIRECTIONS: _____

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