Patient Information

Child's full name: _______________________________ Date of Birth: ___________________ Age: _____ Sex: M or F

Address: ______________________________________ City: ___________________________ State: ______ Zip: ________

***If patient is in care of DCF**, Case Manager Name: _________________________ Contact Number: _____________________

Emergency Contact Name/ Relationship: _________________________________ Phone Number: ____________________

Guardian Information

Guardian #1 Name: _____________________________________ Relationship to child: _____________________________

Address: ______________________________________ City: ___________________________ State: ______ Zip: ________

Home Phone: ______________________ Cell Phone: _______________________Work Phone: _______________________

Email Address: ____________________________________

Guardian #2 Name: _____________________________________ Relationship to child: _____________________________

Address: ______________________________________ City: ___________________________ State: ______ Zip: ________

Home Phone: ______________________ Cell Phone: _______________________Work Phone: _______________________

Email Address: ____________________________________

Physician Information

Physician/Pediatrician Name __________________________________ Facility: ____________________________________

Physician Phone Number: ____________________________________ Physician Fax Number: ________________________

Insurance Information

Please list ***any and all*** insurance plans for which the patient is a beneficiary, even if you know that therapy will not be covered by this plan. This is to ensure that claims are processed appropriately and correctly.

Primary Insurance:

Subscriber's Name: ____ Date of Birth: ______________________________

SSN: __________________________ Employer: ____

Insurance Company Name ___________________________ Phone: ______________________ Fax: ___________________

Member ID #: _____________________________________ Group #: ____

Secondary Insurance (if applicable):

Subscriber's Name: ____ Date of Birth: ______________________________

SSN: __________________________ Employer: ____

Insurance Company Name ___________________________ Phone: ______________________ Fax: ___________________

Member ID #: _____________________________________ Group #: ____