2017 Patient Intake Form

Patient Information

Patient Name: ________________________________ **Date Completed:** ______________

(First, Middle, Last)

DOB: __________________________________ **Sex:** Male Female

(MM/DD/YYYY)

Home Address:

____

____

Best email address(es) for reminders/emails:

____

Patient lives with: Both parents Other: ______________________________

Mother Father

Parents are: Married Divorced Separated Single

Reason for referral:

____

Diagnosis:

____

Caregiver Information

Name: ____________________________________ **DOB:** ________________________

Relationship to patient: ______________________ **Email:** ________________________

Phone: ____________________________________ Home Cell Work

Occupation: ______________________________ **Employer:** _____________________

Employer Address:

____

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<u>Caregiver Information</u>

Name: ____ **DOB:** ____________________________

Relationship to patient: ________________________ **Email:** ____________________________

Phone: ____ Home Cell Work

Occupation: ___________________________________ **Employer:** ________________________

Employer Address:

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<u>Medical Information</u>

Primary Care Physician: ____

Name of Practice: ____

Address: ____

Phone: ______________________________________ **Fax:** ______________________________________

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand that if my information changes at any time, it is my responsibility to notify A to Z Pediatric Therapy, LLC or its billing representative of the noted changes. I also acknowledge that payment for services is due at each visit and I will be billed for any additional services (e.g. consultation, meetings, etc.). A to Z Pediatric Therapy, LLC operates on a fee-for-service basis and is an out-of-network provider. I understand it is my responsibility to understand my benefits.

____ ______________________________________

Print Patient's Name **Date**

____ ______________________________________

Parent/Guardian Signature **Relationship to Patient**

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