



**2018 PATIENT INTAKE**

**Patient Information**

Patient Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

DOB (MM/DD/YY): \_\_\_\_\_ Sex:            Male            Female

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Best email address(es) for contact: \_\_\_\_\_

Patient lives with:             Both parents             Other: \_\_\_\_\_

Mother      Father

Parents are:            Married            Divorced            Separated            Single

Reason for referral: \_\_\_\_\_

Diagnosis code(s): \_\_\_\_\_

**Caregiver I Information**

Caregiver Name: \_\_\_\_\_ Caregiver DOB (MM/DD/YY) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone Carrier: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_

Employer Phone: \_\_\_\_\_

**Caregiver II Information**

Caregiver Name: \_\_\_\_\_ Caregiver DOB (MM/DD/YY) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone Carrier: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_

Employer Phone: \_\_\_\_\_

**\*\*Cell phone carrier is required so that email communications may be sent via text message as needed. \*\***

**\*\*Please do not omit any fields for either caregiver. All information is required and relevant to therapy. \*\***



**Medical Information**

Primary Care Physician: \_\_\_\_\_

Name of Medical 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* 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.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Relationship to Patient