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. **

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info@atozpediatrictherapy.com
www.atozpediatrictherapy.com

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