Pediatrics Unlimited

Be The Best You Can BEE With Therapy

inc.

NEW PATIENT INFORMATION – 2020

Patient Name:	**Date of Birth:**
Parent/Guardian Email:	
Address:	
Parent/Legal Guardian Names:	
Parent/Guardian Phone Numbers:	

Emergency Contacts:

1. Name _____ **Phone #** _____ **Relation** _____

This person may pick up my child in case of emergency? ☐ Yes ☐ No

2. Name _____ **Phone #** _____ **Relation** _____

This person may pick up my child in case of emergency? ☐ Yes ☐ No

Insurance Information: (Please present insurance card if it has changed.)

Primary Insurance:	**ID#:**	
Name of Subscriber:	SS#:	**Date of Birth:**

Secondary Insurance:	**ID#:**	
Name of Subscriber:	SS#:	**Date of Birth:**

Additional Information:

Does your child currently receive therapy at another facility? ☐ Yes ☐ No

If yes, Name of Facility: _____

Please check all that apply. ☐ OT ☐ PT ☐ ST ☐ Aquatic Therapy

*If applicable, what days does your child receive these other therapies? _____

Doctors Who Provide Care To Child: (Please list name and specialty.)

_____

_____

Child's Current Allergies: _____

Child's Current Medications: _____

Parent/Caregiver Signature: _____ **Date:**_____

Office Personnel Signature:_____ Date:_____

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