Pediatrics Unlimited

Be The Best You Can BEE With Therapy

inc.

NEW PATIENT INFORMATION – 2017

In an effort to update our records for the New Year, please fill out the information below:

☐ Patient Name _____ Date of Birth _____

Address _____

City:_____ State:_____ Zip Code:_____ SSN:_____-_____-_____

Parent/Legal Guardian Names: _____

☐ Parent/Guardian Phone Numbers: (H) _____ (C) _____ (W) _____

Parent/Guardian Email: _____

☐ **Emergency Contacts**:

Name _____ Phone Number _____ Relation _____
This person may pick up my child in case of emergency? ☐ Yes ☐ No

Name _____ Phone Number _____ Relation _____
This person may pick up my child in case of emergency? ☐ Yes ☐ No

Name _____ Phone Number _____ Relation _____
This person may pick up my child in case of emergency? ☐ Yes ☐ No

☐ **Insurance Information:** (Please present insurance card.)

Primary Insurance Co._____ID#_____Group_____

Name of Subscriber:_____SSN_____Date of Birth_____

Secondary Insurance Co._____ID#_____Group_____

Name of Subscriber:_____SSN_____Date of Birth_____

Primary Care Physician:_____ Phone #_____

Hospital Preference _____

Does Your Child Currently Receive Any Therapy At Another Facility: Yes or NO

Name of Facility:_____ (Please circle all that apply): OT PT ST AT

If there are any therapies above that your child is not currently receiving but you would like more information, please let us know which you are interested in: _____.

Parent Signature _____ **Date** _____

Office Personnel Signature:_____ Date:_____

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