

# Pediatrics Unlimited

Be The Best You Can BEE With Therapy



## NEW PATIENT INFORMATION – 2018

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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