

Pediatrics Unlimited

Be The Best You Can BEE With Therapy



NEW PATIENT INFORMATION – 2019

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

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

Child's Current Allergies: _____

Child's Current Medications: _____

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

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Office Personnel Signature: _____	Date: _____
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