

In Harmony Pediatric Therapy

Information in this form can be shared with:

- Grow With Me PT
- Rising Stars Children's Therapy, Inc.
- Therabeat, Inc.

Please make a check mark next to new information for 2010

Patient Information Form

NEW INFORMATION!

Name (as appears on insurance card): _____ DOB: _____

Male / Female Parents' Names: _____

Address: _____ City _____ Zip _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ Please circle preferred method of communication.

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Referring Physician (if different): _____

Other doctors and specialists who is involved in your child's care:

Name	Specialty	Phone Number

How did you hear about In Harmony Pediatric Therapy? _____

NEW INFORMATION!

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured SS #: _____ Member ID: _____ Group #: _____

Claims Address (found on back of card): _____

Cust Service #: _____

Secondary Insurance: _____ Name of Insured: _____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Medicaid Number: _____ Effective Date: _____

I understand and agree to the In Harmony Pediatric Therapy, Notice of Privacy Practice.

Signature: _____ Date: _____

NEW INFORMATION!

Family Background

Mother's Name: _____ Age: _____

Occupation _____

Father's Name: _____ Age: _____

Occupation _____

Marital Status: Single Married Divorced Separated Widowed

Languages Spoken at Home (circle primary): _____

Is your child adopted? Y N

Brother(s) and/or Sister(s) of the child:

Name	Age

What are your priorities in coming to therapy?

Has your child previously received therapy services? Yes No

If "Yes", where and when? _____

NEW INFORMATION!

Medical History

At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? Yes No Please describe: _____

Was your child hospitalized after birth? _____

Does your child have any other medial issues? _____

Please list any hospitalizations and/or medical procedures your child has received:

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies: Yes No. If yes, please describe: _____

Education Information

Is your child currently enrolled in school? Yes No

If "Yes", where and days attended: _____

Does your child receive any services through the school? Yes No

If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP)? Yes No

Social/Emotional History

What are your child's favorite toys/activities? _____

What are your child's favorite songs? _____

Is your child currently enrolled in any community activities (music class, play groups, Mother's Morning Out Program)? _____

Anything else you would like to tell us about your or family? _____

Name of Person Completing This Form

Relationship to Child

Date