PEDIATRIC THERAPY SERVICES | where children learn and leap

PATIENT:_____BIRTHDATE:_____AGE:_____ SEX: MALE ☐ FEMALE ☐

ADDRESS:_____CITY_____ZIP_____

HOME PHONE #:_____EMAIL:_____

MOTHER'S NAME _____CELL #_____DOB:_____

EMPLOYER_____WORK#:_____

FATHER'S NAME_____CELL#_____DOB:_____

EMPLOYER_____WORK #:_____

GUARDIAN:_____ PHONE #:_____

ADDRESS:_____CITY_____ZIP_____

PERMISSION TO LEAVE MESSAGE ON ANSWERING MACHINE/PHONE ☐ YES ☐ NO

REFERRING PHYSICIAN:_____

ADDRESS:_____CITY_____ZIP_____

PRIMARY CARE PEDIATRICIAN:_____

ADDRESS:_____CITY_____ZIP_____

DIAGNOSIS: PRIMARY_____SECONDARY_____PH#_____

BRIEF MEDICAL HISTORY/CONCERNS:_____

IS THE PATIENT ADHERING TO THE AMERICAN ACADEMY OF PEDIATRICS ENDORSED VACCINE SCHEDULE? _____

INSURANCE INFORMATION

PRIMARY INSURED:_____INSURANCE CO._____

ID #:_____GROUP#:_____PH#:_____

SECONDARY INSURED:_____ INSURANCE CO:_____

ID #:_____GROUP #:_____PH#:_____

FOR OFFICE STAFF ONLY: RX:_____XRAY:_____

If any changes occur in the information above, please notify PTS in writing.

PRINTED NAME:_____**SIGNATURE:**_____**DATE:**_____

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