AStepAhead
PEDIATRIC THERAPY

WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Name: ______________________________________ Social Security #: __________________ Date of Birth: __________

Address: ____

City/State/Zip: ____

Home phone #: ____ Cell phone#: __________________________________

Sex (circle one): Male Female E-mail Address: ____

Who should we thank for referring you? ____

In case of emergency, who should we contact? ____

Phone ____

PRIMARY INSURANCE

Person Responsible for Account: ____

Relationship to Patient: ________________________ Date of Birth: ______________ Soc. Sec. #: ________________

Address: ____

City/State/Zip: ____ Home phone: ________________________

Responsible party employed by: ______________________________________ Business phone: ____________________

Business address: ____

Insurance company: ____

Insurance company address: ____

Subscriber I.D. #: ______________________________________ Group # ____

ADDITIONAL INSURANCE (if applicable)

Insured name: ____

Relationship to Patient: _________________________ Date of Birth: ______________ Soc.Sec. #: ________________

Address: ____ City/State/Zip: ________________________________

Insured Employed by: ____ Business phone: _____________________

Insurance company ____

Insurance company address: ____

Subscriber I.D. #: ____ Group #: __________________________________

REASON FOR VISIT

Please list your present health concerns, problems or symptoms: ____

____

____

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____

HELPING YOU, HELP YOUR CHILD.

SCHOOL AND THERAPY SERVICES

School/program currently attending: ____ Present grade: _______________

Special services received in school: _______ OT ________ PT ________ Speech Therapy ________ Resource services

Special education ______ Behavior intervention ______ Other special services ___________________________________

Does your child's teacher have concerns about your child's development in any of these areas:

________ Motor skills ________ Social abilities ________ Self-help skills ________ Cognitive skills/learning abilities

Additional Comments: ____

Do you have an IEP from school? Yes ___ No ___ What does it cover? ____

____

RELEVANT MEDICAL INFORMATION

1. Physicians currently involved in your child's care: ____________________________________Phone #:____________

2. Current diagnoses/infections (please list): ____ 3. Recent hospitalizations: _____ No _____ Yes If yes, please describe: ____

4. Recent surgery: _____ No _____ Yes If yes, please describe: ____

5. Diagnostic tests: _____ Bone scan _____ MRI _____ CAT scan _____ Upper GI _____ Swallow study _____ X-rays

Results: ____

6. Medications your child currently takes: ____

7. Special equipment your child uses: ____Splint ____Braces ____Walker ____Crutches ____Wheelchair ____ Other

8. Previous psychological testing: _____ No _____ Yes Results of testing indicate (check all that apply):

______ Learning Disability ______ Attention Deficit Disorder ______ Hyperactivity ______ Mental Retardation

______ Developmental Delay ______ Autism/Pervasive Developmental Disorder _______ Behavioral Disturbance

______ Depression ______ Needs Special Education Services ______ Other

9. Please check all that apply to your child (previous or current):

_______ Seizures _______ G-Tube _______ Food allergies _______ Wears hearing aids _______ Wears glasses

_______ Latex sensitivity _______ Hearing difficulty _______ Vision problem _______ Ear infections

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to A Step Ahead Pediatric Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above provider of services in the office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____Date_______________