



A STEP AHEAD
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: _____

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: _____

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:

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

_____ Latex sensitivity _____ Hearing difficulty _____ Vision problem

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 _____