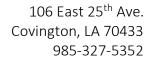


New Patient Intake Form

Patient Information

Child's full name:		
Date of Birth:	Age:	Sex: M / F
Address:		
City:		
Additional information regarding care	e, contact, and restrictions:	
Parent/Guardian Information		
Parent/Guardian's Name (1):		
Address:		
City:	State:	Zip:
Cell Phone:	Home Phone:	
Work Phone:	Email:	·
Parent/Guardian's Name (2):		
Address:		
City:		
Cell Phone:	Home Phone:	
Work Phone:	Email:	
Doctor Information		
Pediatrician's Name:		
Pediatrician's Office Name:		
	Fax Number:	





Insurance Information

- ** Please list all insurance plans for which the patient is a beneficiary, even if you know that therapy will not be covered by this plan.
- ** Please include all commercial insurance policies that list your child as a beneficiary (i.e., Anthem, United Healthcare, Medical Mutual) in order to ensure that claims are processed appropriately.

Primary Insurance:	
Policy Holder'sName:	
Date of Birth:	
Employer:	
Insurance Phone Number:	
ID#:	
Secondary Insurance (if applicable):	
Policy Holder'sName:	
Date of Birth:	
Employer:	
Insurance Phone Number:	
ID#:	Group #: