106 East 25th Ave.
Covington, LA 70433
985-327-5352

New Patient Intake Form

Patient Information

Child's full name:_____

Date of Birth: _____Age:_____ Sex: M / F

Address: _____

City: _____ State:_____Zip:_____

Additional information regarding care, 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: _____State:_____ Zip: _____

Cell Phone: _____Home Phone:_____

Work Phone: _____Email:_____

Doctor Information

Pediatrician's Name:_____

Pediatrician's Office Name:_____

Phone Number: _____ Fax Number: _____

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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 Name:_____

Insurance Address: _____

Insurance Phone Number: _____

ID#: _____ Group #: _____

Secondary Insurance (if applicable):

Policy Holder'sName:_____

Date of Birth:_____

Employer:_____

Insurance Name:_____

Insurance Address: _____

Insurance Phone Number: _____

ID#: _____ Group #: _____