Children are not things to be molded BUT PEOPLE TO BE UNFOLDED

WELCOME TO OUR PRACTICE

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

Client Information

Name: _____

Social Security #: _____ DOB: _____

Address: _____

City/State/ ZIP: _____

Home phone # _____ Cell Phone: _____

Sex (circle one): Male Female Email Address: _____

Chose clinic because/Refereed to clinic by? _____

In case of an emergency, whom should we contact?
_____

Relationship to Client: _____ Phone number: _____

Primary Insurance

Person Responsible for Account: _____

Relationship to Client: _____

Address: _____

City/State/ ZIP: _____

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Copay Amount: _____ Co – Insurance: _____

Reason For Visit: ABA Therapy _____ Speech Therapy _____

Physical Therapy _____ Occupational Therapy _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____

Group # _____

Reason For Visit

Please list all present health concerns, and diagnosis: _____

_____

_____

_____

Other Therapy Services

School/ Programs currently attending: _____ Grade _____

Special services received in school: _____

_____

Do you have an IEP from school? _____

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Medical Information

1. Physicians currently involved in your child's care: _____

2. Current diagnoses / Infections (please list): _____

3. Recent hospitalizations: ____ No ____ Yes (please explain): _____

4. Recent surgery: ____ No ____ Yes (please explain): _____

5. Diagnostic tests: _____ Bone Scan _____ MRI _____ CAT Scan _____ Upper GI _____

   Swallow Study _____ X- rays _____ Results _____

6. Medication your child currently takes: _____

7. Special equipment your child uses: ___ Splint ___Braces ___ Walker _____Other

8. Previous psychological testing: _____ No _____Yes (please explain): _____

_____

_____

_____

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

_____ Seizure _____ G- Tube _____ Food allergies _____ Wears Hearing Aides

_____ Latex sensitivity _____ Hearing difficulty _____ Vision Problem _____ Ear infections

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Authorization and Release

I hereby authorize payment directly to Effective Intervention Services 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 of my dependent(s).

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 _____