A to Z Pediatric Therapy
www.atozpediatrictherapy.com

PATIENT INFORMATION **Date:** _____

Patient Name: _____

DOB: _____ Age: _____ Sex: Male Female

Home Address: _____

_____

Reason for referral: _____

Diagnosis (if known): _____

CAREGIVER INFORMATION (**Please include BOTH caregivers, if applicable)

Parent 1 Name: _____ DOB: _____

Relationship to patient: _____

Phone: _____ Home/Cell/Work

Email: _____

Occupation: _____

Employer: _____

Employer Address: _____

Parent 2 Name: _____ DOB: _____

Relationship to patient: _____

Phone: _____ Home/Cell/Work

Email _____

Occupation: _____

Employer: _____

Employer Address: _____

Parents/Caregivers are:	Single	Married	Divorced	Separated
Child lives with:	Parent 1	Parent 2	Both Parents	Other

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MEDICAL INFORMATION

Primary Care Physician: _____

Clinic/Group Name: _____

Clinic Address: _____

Phone: _____ Fax: _____

FINANCIAL INFORMATION

Person responsible for account: _____

Relationship to patient: _____

Phone: _____ Email: _____

Insurance Name: AETNA BCBS UHC Humana CIGNA Other: _____

Subscriber Name: _____ Subscriber DOB: _____

Policy #: _____ Group #: _____

Employer/Group Name: _____

Does patient have Katie Beckett waiver? Yes No #: _____

Does patient have SSI Medicaid? Yes No #: _____

My signature indicates that, to the best of my knowledge, all information provided above is accurate and current. I understand that if my insurance or Medicaid information changes at any time, it is my responsibility to notify *A to Z Pediatric Therapy, LLC* of the noted changes. Failure to do so will result in my responsibility for payment of services if insurance/Medicaid denies services due to lack of authorization and/or verification of benefits. Please note: verification of benefits does not ensure payment of services. I authorize my insurance and Medicaid benefits be paid directly to A to Z Pediatric Therapy. I understand that I am finally responsible for any balance. I also authorize A to Z Pediatric Therapy to release any information needed to process my claims.

Signature: _____

Date: _____