Children's Therapy Center

☐ Beth Maulhardt, OTR/L
Occupational Therapy

☐ Keiko Goji, DPT
Physical Therapy

☐ Valerie Cummings, PhD
Psychology

Patient Information

Today's Date: _____ /_____ /_____

First Name: _____ M. Initial: _____ Last Name: _____

Male / Female Date of Birth: _____ /_____ /_____ Age: _____ SSN (TRICARE members only): _____ - _____ - _____

Street: _____

City: _____ State: _____ Zip: _____

Name (of insurance policy holder): _____ DOB (of insurance policy holder): _____ /_____ /_____

If patient is under the age of 18, please indicate the adult(s) with whom the minor is under primary care.

Name(s): _____

Circle: Mother Father Stepmother Stepfather Foster Parent Adoptive Parent
Other: _____

Street (if different): _____

City: _____ State: _____ Zip: _____

Phone 1: (_____)_____-_____ Type: _____ Phone 2: (_____)_____-_____ Type: _____

E-mail: _____

Referring physician: _____ Phone: (_____)_____-_____

Front side of insurance card

Back side of insurance card

To the best of my knowledge, the information provided on this paper is true and correct. I will assume all responsibility for any unpaid account balances resulting from insurance claims or outstanding balances in regards to services provided to me or the patient by the name checked off at the top of this page.

Patient/Parent/Guardian Signature: _____

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