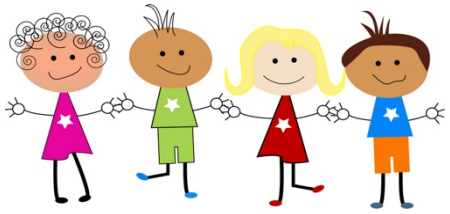
☐ **Beth Maulhardt, OTR/L**
Occupational Therapy



☐ **Keiko Goji, DPT**
Physical Therapy

☐ **Valerie Cummings, PhD**
Psychology

PATIENT INFORMATION

Today's Date: ____/____/____

Patient Name: (L) _____ **(F)** _____ **(MI)** _____
Male / Female **Date of Birth:** ____/____/____ **Age:** _____
Street: _____ **City:** _____
State: _____ **Zip:** _____
Social Security # (TRICARE members only): ____-____-____

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** **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: _____ **Date:** ____/____/____