10862 Portage St NW
Canal Fulton, OH 44614
330-408-7575

EJ THERAPY
Helping you be yourself, by yourself

2714 Akron Road
Wooster, OH 44691
330-262-4449

New Patient Information Form

Date: _____

Child's Name: _____

DOB: _____ Age: _____ Sex: M/F

Child's Address: _____

Parents/Guardian Name: _____

Address: _____

Home phone: _____ Cell number: _____

Email address: _____

Referring Physician/Pediatrician: _____

Physician Phone Number: _____

Medical Diagnosis: _____

Insurance company (primary):_____

Policy Holder's Name: _____ DOB _____

Insured ID #: _____ Group #: _____

Policy # _____

Coverage- How many visits will insurance cover for your child to receive per year? _____

Deductible Amount: _____ Co-pay: _____

Does your plan require pre-authorization for OT/PT/SP visits? Yes_____ No _____

Is child covered another insurance policy? Yes/No

If so, please provide secondary insurance on back of this form.

PLEASE BRING YOUR INSURANCE CARD TO THE FIRST VISIT

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New Patient Medical Information

Child's Name: _____ DOB: _____

Was your child born: _____ full term _____ premature, if so, how many weeks? _____

Was your child placed in NICU following birth? _____ If so, for what reason(s) and how long?

_____

Are your child's immunizations up to date? _____

List allergies:

_____

_____

Current medications:

_____

_____

Does your child use special equipment (ex. Braces, splints, adaptive utensils)?

_____

Has your child received occupational/physical/speech therapy before? If so, how long?

_____

Date of last evaluation

_____

What are main concerns with your child?

_____

_____

Is there anything else our therapists should know regarding your child that may assist us in working with them?

_____

_____

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Release of Information Form

Date: _____

Child's Name: _____

DOB: _____

Parent/Guardian: _____

Address: _____

Phone Number: _____

I. I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, _____ (child's name) to EJ Therapy Services. I understand that this information is to be used for professional purposes only and that it will be regard as confidential. I authorize EJ Therapy Services to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

Signed _____ (insured)

II. I hereby authorize EJ Therapy Services to release therapy records regarding my child, _____ (child's name), to my child's physician, and any clinic, hospital, institution, insurance company, school and other: _____.

Signed _____ (insured)

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Parent's Name: _____

Child's Name: _____

Emergency Number: _____

Allergies:

_____

Other Information:

_____

_____

Parent Permission

Publication of Photograph

I give EJ Therapy the permission to use my child's photograph for advertising, in print or on our website, Facebook, etc and / or other uses in their business.

Child's Name: _____

Parent's Name (Print): _____

Parent's Signature: _____ Date: _____