Whole Kids Therapy Client Data Summary

Client Name: _____ Date of Birth: _____

Social Security Number: _____

Parent(s)/Guardian: _____

Address: _____

Phone: _____ (home) _____ (cell)

Email: _____

What is the most convenient way/time to contact you? _____

Guarantor Name: _____

Relationship to Client: _____

Address (if different from client): _____

Phone (if different from client): _____ (home) _____ (cell)

Employer Name: _____ Work Phone: _____

Employer Address: _____

Referred By: _____

Reason for Referral/Parent Concerns: _____

_____

_____

Primary Care Physician: _____

Emergency Contact(s): _____

_____

First Insurance Information:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____

Whole Kids Therapy Client Data Summary

Policy Holder's Date of Birth: _____/ _____/ _____ Gender: M/F

Second Insurance Information:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth: _____/ _____/ _____ Gender: M/F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Whole Kids Therapy. I acknowledge that I am personally responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

Medical History (length of gestation, birth complications if any, illness, diagnoses, etc.)

_____

_____

_____

_____

Motor Milestones – at what age did your child:

Sit up independently _____

Roll over _____

Crawl, and for how long _____

Stand independently _____

Walk independently _____

Please list any food allergies your child has, or if they are on a special diet: _____

_____