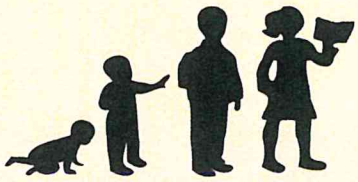
A Step Ahead
PEDIATRIC THERAPY



WELCOME TO OUR PRACTICE

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____
Sex (circle one): Male Female
Address: _____
City/State/Zip: _____
Home Phone #: _____ Cell Phone#: _____
I agree to allow A Step Ahead Pediatric Therapy to send me automated text messages to the number I have provided for appointment reminders (circle one): YES NO
E-mail Address: _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Relationship? _____
Phone _____

PRIMARY INSURANCE

Insurance Policy Holder: _____
Relationship to Patient: _____ Date of Birth: _____ Soc. Sec. #: _____
Address: _____
City/State/Zip: _____ Home Phone: _____
Responsible Party Employed By: _____ Business Phone: _____
Business Address: _____
Insurance Company: _____
Insurance Company Address: _____
Subscriber I.D. #: _____ Group # _____

ADDITIONAL INSURANCE (if applicable)

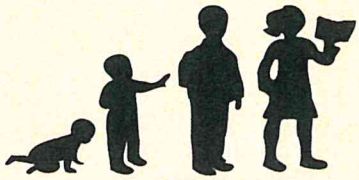
Insurance Policy Holder: _____
Relationship to Patient: _____ Date of Birth: _____ Soc. Sec. #: _____
Address: _____ City/State/Zip: _____
Responsible Party Employed By: _____ Business Phone: _____
Insurance Company _____
Insurance Company Address: _____
Subscriber I.D. #: _____ Group #: _____

REASON FOR VISIT

Please list your present health concerns, problems, or symptoms: _____
_____
_____
_____

PH: 859.426.5666 | FX: 859.426.5665 | 330 Thomas More Parkway, Ste. 102 | Crestview Hills, KY 41017

A Step Ahead PEDIATRIC THERAPY



SCHOOL AND THERAPY SERVICES

School/Program Currently Attending: _____ Present grade: _____

Special Services Received in School: ☐ OT ☐ PT ☐ Speech Therapy ☐ Behavior Intervention

☐ Resource Services Special Education ☐ Other special services_____

Does your child's teacher have concerns about your child's development in any of these areas:

☐ Motor skills ☐ Social abilities ☐ Self-help skills ☐ Cognitive skills/learning abilities

Additional Comments: _____

Do you have an IEP from school? ☐ Yes ☐ No What does it cover? _____

_____

RELEVANT **MEDICAL INFORMATION**

1. Physicians currently involved in your child's care: _____Phone #: _____
2. Current diagnoses/infections (please list): _____
3. Recent hospitalizations: ☐ No ☐ Yes If yes, please describe: _____
4. Recent surgery: ☐ No ☐ Yes If yes, please describe: _____
5. Diagnostic tests: ☐ Bone scan ☐ MRI ☐ CAT scan ☐ Upper GI ☐ Swallow study ☐ X-rays
   Results: _____
6. Medications your child currently takes: _____
7. Special equipment your child uses: ☐ Splint ☐ Braces ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Other
8. Previous psychological testing: ☐ No ☐ Yes
   Results of testing indicate (check all that apply):
   ☐ Learning Disability ☐ Attention Deficit Disorder ☐ Hyperactivity ☐ Developmental Delay
   ☐ Autism/Pervasive Developmental Disorder ☐ Behavioral Disturbance ☐ Depression
   ☐ Needs Special Education Services ☐ Other
9. Please check all that apply to your child (previous or current):
   ☐ Seizures ☐ G-Tube ☐ Food allergies ☐ Wears hearing aids ☐ Wears glasses ☐ Latex sensitivity
   ☐ Hearing difficulty ☐ Vision problem ☐ Ear infections

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to A Step Ahead Pediatric Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Signature _____ Date _____

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