Pediatric Therapy Services, Inc.

Occupational, Physical, Speech-Language Therapy

----------------------*BE YOUR BEST WITH PTS*-----------------------

DATE: ____________________ DOB:__________________________

PATIENT NAME: ____SEX: MALE ☐ FEMALE ☐

ADDRESS:____CITY_____________ZIP__________

PHONE #:________________________CELL #:__________________EMAIL: ___________________________

FATHER'S NAME /SS#____DOB________________

PLACE OF EMPLMNT____________________________OCCUPATION_____________WORK NO:________________

MOTHER'S NAME/ SS#____DOB________________

PLACE OF EMPLMNT____________________________OCCUPATION_____________WORK NO:________________

GUARDIAN:____ PHONE #:______________________

PERMISSION TO:LEAVE MESSAGE ON ANSWERING MACHINE ☐ YES ☐ NO / PLACE OF EMPLOYMENT ☐ YES ☐ NO

REFERRING PHYSICIAN:____

MAILING ADDRESS:____PH#_________________

PRIMARY CARE PEDIATRICIAN:____

MAILING ADDRESS:____PH#_______________________

DIAGNOSIS:____

BRIEF MEDICAL / HISTORY CONCERNS____

____

____

____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

INSURANCE CO: ________________________________INSURED'S NAME:_________________________

ID #:____GROUP #:_____________________________________

PHONE #:______________________________________MEDICAID #:__________________________________

SECONDARY INSURANCE CO:__________________________________PHONE #:________________________

INSURED'S NAME:____

ID #:____GROUP #:_____________________________________

If any changes occur in the information above, please notify PTS in writing.

Signature:____Date:__________________________

IF INFORMATION ABOVE IS THE SAME, PLEASE:

____________	______	____________	______	____________	______
INITIAL	DATE	INITIAL	DATE	INITIAL	DATE

FOR OFFICE STAFF ONLY: RX:________________ XRAY:______________

1215 E Orange Street▪ Lakeland FL 33801-4762 ▪ (863) 802.3800 ▪ Fax (863) 802.0480
206 Ridgewood Avenue ▪ Brandon FL 33510-4617 ▪ (813) 662.1060 ▪ Fax (813) 662.0530