Therapy Solutions For Children , Inc.

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Patient Intake and Registration Form

Today's Date: _____

Child's Full Name:_____ DOB:_____

Mother's Name:_____ DOB:_____
Address:_____ Home #:_____
_____ Cell #:_____
Father's Name: _____ DOB: _____
Address:_____ Home #:_____
_____ Cell #:_____

May TSFC contact you by email? (Please check one)
____ Yes, I give OTS permission to contact me via email in terms of sending me my updated financial balance statement. Here is my email address: _____
_____ No, I do not wish to use email to be contacted by TSFC.

Child's Medical Diagnosis:_____ Referred by:_____
Referring Physician:_____Drs' Phone #:_____
Child's School:_____Grade:_____

INSURANCE INFO

Primary Ins Carrier: _____ Subscriber: _____
Effective Date:_____ Subscriber's SSN:_____
ID#:_____ Subscriber DOB _____
Group #_____ Employer:_____
Membership #_____ Child's Relationship to Subscriber:_____
Claims Addressed to:_____

Secondary Insurance _____ Subscriber:_____
Effective Date:_____ Subscriber's SSN:_____
ID#:_____ Subscriber DOB:_____
Group #_____ Employer:_____
Membership #_____
Claims Addressed to:_____