

Helping Hands Pediatric Therapy, Inc.

Patient Information

Patient's Legal Name (last, first, middle) _____

Diagnosis: _____

Date of Birth: _____ Age: _____ Sex: _____

Home Phone: _____ Home Address: _____

City: _____ State: _____ Zip Code: _____

Legal Guardian/Guarantor Name (last, first, middle): _____

Relation to Patient: _____ Date of Birth: _____

Social Security Number: _____

Email Address: _____

Employer Name: _____

Other Phone Numbers: _____

Related Services

1. Service: _____ Provider: _____ Phone: _____

2. Service: _____ Provider: _____ Phone: _____

3. Service: _____ Provider: _____ Phone: _____

4. Service: _____ Provider: _____ Phone: _____

5. Service Coordinator: _____

Insurance Information

Primary Insurance Plan Name: _____

Policy #: _____ Group #: _____

If Medicaid Recipient, Insurance Carrier Code: _____

Insured Relation to Insured's

Patient: _____ Employer: _____

Claims Address: _____

Phone #: _____ Fax #: _____

Secondary Insurance Plan Name: _____

Policy #: _____ Group #: _____

Insured Relation to Insured's

Patient: _____ Employer: _____

Claims Address: _____

Phone #: _____ Fax #: _____

Babies Can't Wait Program? Yes No If Yes, District #: 3-4

Family Cost Participation %: 0

Pediatrician's Primary Care Physician Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____