PATIENT INFORMATION FORM

We are happy to welcome your child to our practice!

Questions? Please call us at 303-756-0280

Please complete this form entirely, before submitting it to INFO@SP4KIDS.COM DATE _____

CHILD - Legal Name _____ Nick Name _____ DOB _____ Age _____ Sex ____

Preferred Location for Services ☐ **DTC**, near Belleview and I-25 ☐ **Wheat Ridge**, near Kipling and I-70

Parent/Guardian - Legal Name _____ ☐ *lives with child*

Cell # _____ Email _____

Mailing Address _____
Street Unit/Apt # City State Zip

Parent/Guardian - Legal Name _____ ☐ *lives with child*

Cell # _____ Email _____

Mailing Address (if different from above) _____
Street Unit/Apt # City State Zip

INSURANCE - Primary _____ ID# _____ Group # _____

Insured Parent Legal Name _____ Insured DOB _____

INSURANCE - Secondary _____ ID# _____ Group # _____

Insured Parent Legal Name _____ Insured DOB _____

Physician - Full Name _____ Practice Name _____

Practice Location _____ Phone _____ Fax _____

School - _____ Grade _____ Teacher _____

Referred By _____

Diagnosis/es _____ Medications _____

Comments _____

FOR OFFICE USE ONLY

INTAKE	Day	Date	Time	Therapist		Bene Req	Conf Cov
EVALUATION	Day	Date	Time	Therapist	LOCATION	Received	RX??
Called/Emailed	Wel Ltr	Web PT	Reminders:			Provided	Auth??
Notes							