134 Hall Street, Unit 1
Concord, NH 03301-3470
603-224-4540 Fax: 603-228-7384 e-mail: pediatricptinc@itsabilitypt.com

PATIENT INFORMATION

Patient's Last Name: ________________ First Name: ________________ Middle Initial: ____

Patient's Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Parent/Guardian:____

Home Address: ____

City: _________________________ State: _________________Zip:__________________

Phone: (H)___________________ (W)______________________ (C)______________________

E-mail:____

Patient's Diagnosis: ________________________________Date First Diagnosed: ____________

Patient's Primary Physician: ____

Address: ____ Phone: ________________

Patient's Specialist (Orthopedist, audiologist, etc):______________________________________

Address: ____ Phone: ________________

Is the Patient Currently Receiving Speech, Physical or Occupational Therapy elsewhere? Yes No

Related Surgical History:____

____

Special Equipment Needs: ____

Special Medical Needs (Allergies, etc): ____

____

INSURANCE INFORMATION

Person Responsible for Payment: ____

Primary Insurance: ____

Address: ____

ID#: ________________________________

Group#:_____________________________________

Name of Subscriber: _________________________ Employed By:_________________________

Secondary Insurance:____

Address: ____

ID#: ________________________________

Group#:_____________________________________

Name of Subscriber: _________________________ Employed By:_________________________

Medicaid#: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

I give permission for IT'S ABILITY, to evaluate and treat my child, to submit claims to the above named insurance carrier(s) for my child's physical therapy services and authorize the release of any medical information to process this claim. I also authorize payment of medical benefits to IT'S ABILITY for physical therapy services.

Parent/Guardian Signature:_____________________________________Date:_____/_____/_____

THANK YOU!!