**New Patient Intake Form**

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| CHILD INFORMATION | | | | | | PARENT/GUARDIAN INFORMATION | | | | | | |
| **Name** | Click here to enter text. | | | | | **Mother** | Click here to enter text. | | | | | |
| Date of birth | Click here to enter text. | | Age | | Click here to enter text. | DOB | Click here to enter text. | | | Home Ph | | Click here to enter text. |
| Gender | Click here to enter text. | | Doctor | | Click here to enter text. | Cell Ph | Click here to enter text. | | | Work Ph | | Click here to enter text. |
| Person Referring | | | Click here to enter text. | | | *Mailing Address* | | Click here to enter text. | | | | |
| Medical Diagnosis | | | Click here to enter text. | | | City, State, Zip | | Click here to enter text. | | | | |
| Current immunizations? | | | Yes  No | | | *Physical Address* | | Click here to enter text. | | | | |
| If “NO” give reason | | | Click here to enter text. | | | City, State, Zip | | Click here to enter text. | | | | |
| Child resides with? | | | Parents  Foster | | | Occupation | | Click here to enter text. | | | | |
| Who has custody of child? | | | Parents  OCS | | | Employer | | Click here to enter text. | | | | |
| *OCS Caseworker.* | | | Name | Click here to enter text. | | **Father** | Click here to enter text. | | | | | |
| Cell | Click here to enter text. | | DOB | Click here to enter text. | | | Home Ph | | Click here to enter text. |
| *Person other than parent bringing child to therapy.* | | | Name | Click here to enter text. | | Cell Ph | Click here to enter text. | | | Work Ph | | Click here to enter text. |
| Cell | Click here to enter text. | | *Mailing Address* | | Click here to enter text. | | | | |
| PRIMARY INSURANCE INFORMATION | | | | | | City, State, Zip | | Click here to enter text. | | | | |
| Primary Insurance | | Click here to enter text. | | | | *Physical Address* | | Click here to enter text. | | | | |
| Policy Number | | Click here to enter text. | | | | City, State, Zip | | Click here to enter text. | | | | |
| Group Number | | Click here to enter text. | | | | Occupation | | Click here to enter text. | | | | |
| Expiration | | Click here to enter text. | | | | Employer | | Click here to enter text. | | | | |
| Claims Address | | Click here to enter text. | | | | ***May we send out an appointment reminder via text or email?***  Yes  No  Text Cell ph #: Click here to enter text.  Email Email Address:Click here to enter text.  Both  ***May we email requested medical records to you?***  YesNo Email Address:Click here to enter text.  I authorize AKT, KKT, and/or ORS to submit bills directly to the insurance carrier(s) for payment.  I authorize insurance carrier(s) to make payments to AKT, KKT, and/or ORS.  I understand that KKT and/or ORS may be billing the Infant Learning Program (ILP) for my child while enrolled in ILP. Once my child is discharged from ILP, I hereby give KKT and/or ORS permission to bill my insurance carrier(s) directly for payment. | | | | | | |
| Phone Number | | Click here to enter text. | | | |
| Insured’s Name | | Click here to enter text. | | | |
| Insured’s DOB | | Click here to enter text. | | | |
| SECONDARY INSURANCE INFORMATION | | | | | |
| Secondary Insurance | | Click here to enter text. | | | |
| Policy Number | | Click here to enter text. | | | |
| Group Number | | Click here to enter text. | | | |
| Expiration | | Click here to enter text. | | | |
| Claims Address | | Click here to enter text. | | | |
| Phone Number | | Click here to enter text. | | | |
| Insured’s Name | | Click here to enter text. | | | |
| Insured’s DOB | | Click here to enter text. | | | |
| **Parent or Legal Guardian Signature** | | |  | | | | | | **Date** | |  | |

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| **Name of Child** | | | | | | | | | |
| List all the names of providers and programs that have worked with or are currently providing services to your child.  *\* Physicians, teachers, therapists, day care, counselor, etc.* | | | | | | | | | |
| **Name of Provider and Program** | | | | **Phone Number** | | | **Dates** | | |
| Click here to enter text. | | | | Click here to enter text. | | | Click here to enter text. | | |
| Click here to enter text. | | | | Click here to enter text. | | | Click here to enter text. | | |
| Click here to enter text. | | | | Click here to enter text. | | | Click here to enter text. | | |
| Click here to enter text. | | | | Click here to enter text. | | | Click here to enter text. | | |
| PERMISSIONS | | | | | | | | | |
| I give permission for students/shadows to observe my child for the purpose of education. | | | | | | | | | |
| I give permission to photograph/videotape my child for the purposes of treatment, education, and/or documentation. | | | | I give permission to photograph/videotape my child to be used for advertising, brochure, and/or web space. | | | | | |
| Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA) | | | | | | | | | |
| I acknowledge that I have viewed and been offered a copy of the Notice of Privacy Practices. | | | | | | | | | |
| EMERGENCY CONTACT NAME (other than self) | | | | | | | | | |
| Name | Click here to enter text. | | Relationship | Click here to enter text. | Phone Number | | | | Click here to enter text. |
| Name | Click here to enter text. | | Relationship | Click here to enter text. | Phone Number | | | | Click here to enter text. |
| EMERGENCY MEDICAL RELEASE | | | | | | | | | |
| As legal guardian of this child, I give my permission for AKT, KKT, and ORS, in the event medical attention is required for your child while on the premises of AKT, KKT, and ORS to provide basic life support medical treatment and/or to contact emergency personnel in the event of a medical emergency. | | | | | | | | | |
| EVALUATION CONSENT | | | | | | | | | |
| During the evaluation the therapist may assess your child’s abilities in one or more of the following areas: communication, social, play, problem solving, sensory, motor, body structures. The evaluating therapist may use one or more of the following procedures: caregiver interview, medical record review, clinical observation, developmental tests, body structure exam. Minor risks may include irritability, fatigue, and/or tired muscles.  Igive consent for my child to be evaluated today. | | | | | | | | | |
| TREATMENT CONSENT | | | | | | | | | |
| Following evaluation the therapist will review the findings with you and recommend treatment interventions for your child. Therapeutic interventions in one or more of the following areas may include: education, home program, communication, language, social, play, daily living activities, sensory, motor, exercise, positioning, taping, orthotics, equipment fitting. Minor treatment risks may include irritability, fatigue, and/or tired muscles.  If treatment is recommended Igive consent for my child to receive the agreed upon therapeutic interventions. | | | | | | | | | |
| **Parent or Legal Guardian Signature** | |  | | | | **Date** | |  | |