IT'S ABILITY
Pediatric Physical Therapy

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

PATIENT INFORMATION

Child's Last Name: _____ First Name: _____ Middle Initial: ____

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

Parent/Guardian:_____

Home Address: _____

City: _____ State: _____Zip:_____

Phone: (H)_____ (W)_____ (C)_____

E-mail:_____

Child's Diagnosis: _____Date First Diagnosed: _____

Child's Pediatrician: _____

Address: _____ Phone: _____

Child's Specialist (Orthopedist, audiologist, etc):_____

Address: _____ Phone: _____

Is Your Child 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!!