

Patient Registration Packet

Date:

Patient's Name:		Age:	Date of Birth:
Service Requested:			
Physician's Address:		City/State/Zip Code:	
School Attends:		Grade:	
Please describe your concern:			
How did you hear about our service:			
Mother's Name:		Father's Name:	
Home Address:		Home Address:	
City/State/Zip Code:		City/State/Zip Code:	
Home: () - Work: () -		Home: () - Work: () -	
Mobile: () -		Mobile: () -	
Occupation:		Occupation:	
Business Name:		Business Name:	
Business Address:		Business Address:	
City/State/Zip Code:		City/State/Zip Code:	
Do you wish to have insurance filed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insured's Name:		Insured's Date of Birth:	
Insured's SS#:		Patient's SS#:	

Child's Personal Profile

Name:	Date of Birth:
Age:	Sex:
Address:	
City/State/Zip Code:	
Home: () - Work: () -	Mobile: () -
Diagnosis (if any):	
Primary Care Physician:	Work: () -
Referring Physician:	Work: () -
The Purpose of the Release is:	Disposition of Records:
<input type="checkbox"/> Continuity of Care	<input type="checkbox"/> To Be Mailed
<input type="checkbox"/> Reimbursement / Insurance	<input type="checkbox"/> Will Call for Pick Up
<input type="checkbox"/> Personal	
<input type="checkbox"/> Other	

Child's Family Information

Mother's Name:	Date of Birth:
Father's Name:	Date of Birth:
Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Separated	
If child is from a previous marriages:	

Stepfather/Mother Name:	Date of Birth:
Who has custody of the child:	

Referral Information

Who referred you:		
Please write a description of the child's issues as you see it. Please include any information you feel is necessary:		
Has the child been evaluated for any of the issues listed above? If so by whom:		
Difficulties Following Birth:	Difficulties During Infancy:	
<input type="checkbox"/> Needed Oxygen	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Irritable
<input type="checkbox"/> Needed Incubation	<input type="checkbox"/> Limp	<input type="checkbox"/> Jittery
<input type="checkbox"/> Had Trouble Suckling	<input type="checkbox"/> Rigid	<input type="checkbox"/> Overactive
<input type="checkbox"/> Intubation	<input type="checkbox"/> Colic	
<input type="checkbox"/> Other		
Length of Hospital Stay:		

Child's Medical History

Childhood illnesses (Please indicate age and frequency)					
<input type="checkbox"/> Ear Infections	Age:	Freq.:	<input type="checkbox"/> Tubes in Ears	Age:	Freq.:
<input type="checkbox"/> Tonsillitis	Age:	Freq.:	<input type="checkbox"/> High Fever	Age:	Freq.:
<input type="checkbox"/> Frequent Colds	Age:	Freq.:	<input type="checkbox"/> Respiratory Infections	Age:	Freq.:
Allergies: (Please List All):					
Seizures: (How often, when was the last one?):					
Please list and describe any significant injuries, illnesses or major operations along with the dates:					
Has the child been to a Neurologist? If yes, whom and what were the results?					
Has vision been examined?	Date:	Results:			
Does the child wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No At what age were they prescribed?					
Has hearing been tested?	Date:	Results:			
Does the child wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No At what age were they prescribed?					
Please list any medication the child is taking along with the reason they were prescribed:					

Child's Development History

Please Note When Each Occurred:		
Sat up without help:	Feed Self:	Crawled:
Walked:	Bladder Control	Bowel Control:
Spoke 1 st word:	Dressed Self:	Put words together:
Was your child bottle-feed? Any problems?		
Did / Does your child have problems with an exaggerated gag reflex?		
Did / Does your child have problems eating?		
Where there periods when your child quit talking? Describe:		

Child's Education

If your child is not in school yet. Where does he/she stay during the day?	
If your child is in school, please complete the following:	
Name of School:	Grade / Level:

Type of classes: Regular Special Education Life Skills Other

If Special Education, what label was used to qualify your child?

Does your child receive therapy at school? If so, what type and how often?

Who is his/her therapist?

Child's Family History

Siblings:	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Other persons living at home, and their relationship to the child:	
Language spoken at home:	

Has anyone in the family ever had a history of speech, language, swallowing, hearing, or learning problems? If yes, please describe:

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If your child requires therapy, what are your personal goals / expectations? What would you like you child to learn? Please describe:

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Parent / Guardian Signature:	
Parent / Guardian Print Name:	
Relationship:	
Date:	

Consent Authorization Form

Consent for Treatment

I hereby voluntarily consent to such medical care treatment, including any diagnostic procedures and tests to be performed on the patient named herein that the patient's physician, his or her associates, assistants and other health care providers believe are necessary for the care of the patient. I hereby state that I have the legal right to the medical treatment of the patient listed herein. In the course of treatment, I understand and acknowledge that no warrant or guaranty will be made as to the result of treatment.

Initials []

Permission to Photograph

I authorize The Therapy S.P.O.T. to photograph my child. I give my consent to allow The Therapy S.P.O.T. to display the photographs in their office and to be in the public view. These photos will not be purchased and/or duplicated by any other source.

Initials []

Authorization to Release or Request Information

Patient Name:	Date of Birth:
Address:	
Phone:	Date of Service:

I, the undersigned, hereby authorize The Therapy Spot to release or receive the information described below:

<input type="checkbox"/> Abstract (Includes: Face Sheet and H&P)	<input type="checkbox"/> All Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Evaluations
<input type="checkbox"/> Other	

Message:

Patient's Name:	Date:
Parent / Guardian Signature (Relationship)	Date:

Tardiness, No Show, and Cancellation Policy

We are working with you to provide the highest quality treatment and services for children and their families in our community.

In order to provide quality therapy for your child in a timely manner, the following policy will be implemented for all patients effective Friday, July 1, 2005:

- ✓ If a patient is more than 10 minutes late to his/her visit, the appointment will be automatically cancelled. You may request to reschedule the visit for another appointment, if our schedule permits.
- ✓ If a patient misses 25% or more of his/her scheduled appointments, visits will be reduced to 1 visit per week for the following month.
- ✓ If the no shows or cancellations continue (misses 50% of scheduled visits), the patient will be removed from the schedule until further notice.

An excused missed visit includes:

- ✓ 24 hour or more notice of cancellation prior to the scheduled appointment.
- ✓ Notice from doctor, school, etc. stating the reason for the missed visit with date and time.

Any other absences will be considered unexcused and documented as such.

Thank you for choosing The Therapy Spot for your speech, physical, and occupational therapy services!