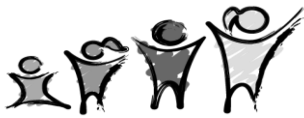

Pediatric Therapy Services, Inc.
Making a difference…one child at a time

150 St. Andrews Ct. | Suite 310 | Mankato, MN 56001
Phone: 507-388-KIDS (5437) | Fax: 507-388-2108
www.kidtherapy.com | Email: ptskids@kidtherapy.com

Today's Date_____________

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME: ______________________________ SEX: _____ DOB: _____-_____-_____
LAST FIRST MI M/F MO DAY YR

HOME PHONE: ___________________________

ADDRESS: ______________________________CITY: _____________STATE: _______ ZIP: __________

REFERRING PHYSICIAN: ________________________ PRIMARY CARE PHYSICIAN: ________________________

REFERRING PHYSICIAN PHONE: ______________________ PRIMARY CARE PHYSICIAN PHONE: ______________________

ALLERGIES/PRECAUTIONS:

Does your child have any allergies, seizures, or precautions? If so, please list and describe:

RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN)

NAME: ______________________________ DATE OF BIRTH: ______-______-_______
LAST FIRST MI MO DAY YR

RELATION TO PATIENT:_______________________________

ADDRESS: ______________________________CITY: _______________STATE: _______ ZIP: ________

HOME PHONE: ___________________________ WORK PHONE: ________________________ CELL PHONE: _________________________

EMAIL ADDRESS: ______________________________________

PREFERRED METHOD OF COMMUNICATION: Home Ph. _______ Cell Ph._______ Work Ph. _______ Email: _______ Mail: _______

NAME: ______________________________ DATE OF BIRTH: ______-______-_______
LAST FIRST MI MO DAY YR

RELATION TO PATIENT:_______________________________

ADDRESS: ______________________________CITY: _______________STATE: _______ ZIP: ________

HOME PHONE: ___________________________ WORK PHONE: ________________________ CELL PHONE: _________________________

EMAIL ADDRESS: ______________________________________

PREFERRED METHOD OF COMMUNICATION: Home Ph. _______ Cell Ph._______ Work Ph. _______ Email: _______ Mail: _______

INSURANCE

PRIMARY INSURANCE: ____________________________________ POLICY NUMBERS: ______________________________________
(ID#) (GROUP/PLAN#)

POLICY HOLDER: ____ EMPLOYER: ____________________________________
LAST FIRST MI

DATE OF BIRTH: _______-_______-________ SS#: _________-________-__________ RELATION TO PATIENT:________________________
MO DAY YR

INSURANCE PHONE: ____

SECONDARY INSURANCE: ____________________________________ POLICY NUMBERS: ______________________________________
(ID#) (GROUP/PLAN#)

POLICY HOLDER: ____ EMPLOYER: ____________________________________
LAST FIRST MI

DATE OF BIRTH: _______-_______-________ SS#: _________-________-__________ RELATION TO PATIENT:________________________
MO DAY YR

INSURANCE PHONE: ____________________________________ MINNESOTA MA: _____YES _____ NO ID# _______________________

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NAME ____ **DATE OF BIRTH** ________________

RELEASE OF INFORMATION

I authorize the exchange of Protected Health Information between Pediatric Therapy Services, Inc., and the specified individuals listed below:

PRIMARY DOCTOR/CLINIC:____ PHONE #: ________________________

SPECIALTY DOCTOR.CLINIC: ____ PHONE #: ________________________

____ PHONE #: ________________________

PRESCHOOL/SCHOOL DISTRICT: ____ PHONE #: ________________________

SOCIAL WORKER: ____ PHONE #: ________________________

OTHER: ____ PHONE #: ________________________

____ PHONE #: ________________________

OTHER CONTACTS

Please list other individuals who are involved in taking care of the patient, such as caregiver and/or relative other than guardian, with whom you authorize Pediatric Therapy Services, Inc. to discuss/exchange information regarding the patient's treatment.

NAME: ____ RELATION TO PATIENT: ______________________
LAST FIRST MI

HOME PHONE: ________________________ CELL PHONE: ___________________

NAME: ____ RELATION TO PATIENT: ______________________
LAST FIRST MI

HOME PHONE: ________________________ CELL PHONE: ___________________

PTS, Inc. occasionally videotapes/photographs for lecture, training, webpage and/or marketing.
I give PTS, Inc. permission to photograph/videotape my child for the following purposes:

Professional Lecture/Training: Yes/No **Webpage: Yes/No** **Marketing Materials: Yes/No**

AUTHORIZATIONS and ACKNOWLEDGEMENTS

1. I have received the Notice of Privacy Practices from Pediatric Therapy Services, Inc.
2. I have received the Patient Service Agreement from Pediatric Therapy Services, Inc.

SIGNATURE: X ____ DATE: ______________
Parent/Legal Guardian

I hereby authorize PEDIATRIC THERAPY SERVICES, INC. to furnish information concerning treatments to INSURANCE CARRIERS, PHYSICIANS, and THERAPISTS AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to PEDIATRIC THERAPY SERVICES, INC. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X ____ DATE: ______________
Parent/Legal Guardian