

Date: \_\_\_\_\_



Diagnosis: \_\_\_\_\_

 NEW PATIENT EXISTING PATIENT UPDATE

PATIENT INFORMATION			PRIMARY INSURANCE	
LAST NAME:	FIRST NAME:	MI	PLAN NAME:	PHONE NUMBER:
ADDRESS:			CLAIMS ADDRESS:	
CITY:	STATE:	ZIP:	POLICY/MEMBER NUMBER:	GROUP NUMBER:
PHONE WITH AREA CODE:		COUNTY:	START DATE:	END DATE:
SEX:	SOCIAL SECURITY NUMBER:		DATE OF BIRTH	
SUBSCRIBER/POLICY HOLDER:				
RESPONSIBLE PARTY INFORMATION			SECONDARY INSURANCE	
NAME:			PLAN NAME:	PHONE NUMBER:
ADDRESS:			CLAIMS ADDRESS:	
PHONE WITH AREA CODE:		RELATION TO PATIENT:	POLICY/MEMBER NUMBER:	GROUP NUMBER:
OCCUPATION:	SOCIAL SECURITY NUMBER:		START DATE:	END DATE:
EMPLOYER:			SUBSCRIBER/POLICY HOLDER:	
ADDRESS:			REGULAR/PRIMARY PHYSICIAN	
PHONE WITH AREA CODE:			PHYSICIAN:	
EMAIL ADDRESS:			ADDRESS:	
EMERGENCY CONTACT INFORMATION			PHONE WITH AREA CODE:	
NAME:			REFERRING PHYSICIAN	
ADDRESS:			PHYSICIAN:	
HOME AND/OR WORK PHONE WITH AREA CODE:			ADDRESS:	
RELATION TO PATIENT:			PHONE WITH AREA CODE:	

I understand and agree that I am ultimately responsible for payment for services rendered. I certify this information is correct and true to the best of my knowledge. I give permission for my child to receive the following services through Tender Touch Therapy. (initial) \_\_\_\_ Speech Therapy, \_\_\_\_ Physical Therapy, \_\_\_\_ Occupational Therapy.

**Signature/Relationship to patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_