STONES WORTH STEPPING, P.C.
PEDIATRIC PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

Patient Name_____
(Last) (First) (MI)

Address_____City_____State_____Zip_____

Phone #_____Sex____Date of Birth_____ Patient SSN_____

Primary Care Physician_____Phone #_____

Referred By_____Phone #_____

Parent's Name_____Parent Date of Birth_____

Home Phone #_____Cell Phone #_____Parent SSN_____

Email_____

Parent Employer_____Employer Phone #_____

Spouse Name_____Spouse Date of Birth_____

Home Phone #_____Cell Phone #_____Spouse SSN_____

Email_____

Spouse Employer_____Employer Phone #_____

Emergency Contact_____Relationship_____

Address_____Phone #_____

PRIMARY INSURANCE INFORMATION (all fields are Required)

Insurance Company_____Phone #_____

ID #_____Group #_____

Cardholder's Name_____Relationship to Patient_____

SECONDARY INSURANCE INFORMATION (all fields are Required)

Insurance Company_____Phone #_____

ID #_____Group #_____

Cardholder's Name_____Relationship to Patient_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: STONES WORTH STEPPING, P.C.
I acknowledge that it is my responsibility to know my insurance benefits for occupational, physical and speech therapy services. I assume responsibility for payments denied by my insurance company.

_____
(Signature)