Alaska Pediatric Therapy

Patient Intake Form

Child's Name:_____ Date of Birth:_____

Pediatrician:_____ Phone:_____

Mother/Guardian:_____ Father/Guardian:_____

Address:_____ Address:_____

_____ _____

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

□Text Reminders/Alerts □Text Reminders/Alerts

Email:_____ Email:_____

□Email Reminders/Alerts □Email Reminders/Alerts

Employer:_____ Employer:_____

Child Resides With:_____

**Emergency Contact Information:**

Name:_____Phone:_____Relation To Child:_____

Insurance Information:

Primary Insurance:_____ Secondary Insurance:_____

Policy #:_____ Policy #:_____

Group #:_____ Group #:_____

Insured's Name:_____ Insured's Name:_____

Insured's DOB:_____ Insured's DOB:_____

Insured's SSN:_____ Insured's SSN:_____

**Please notify us immediately if there is every a change of insurance. Some insurance companies such as Tricare/United Health Care require prior authorization. We would not be able to retroactively bill if there were a change we were not notified of, this would result in a patient balance.