|  |  |
| --- | --- |
|

|  |
| --- |
| **Kidz Therapy Zone** |

**214 S. Dillard St.****Winter Garden, FL 34787****407-877-0029****Fax 407-358-5207** |

**Patient-Child’s Info**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Last, First) | Age | Birth Date | Sex |
| Mailing Address | City | State | Zip Code | Marital Status |
| Primary Diagnosis | Primary Numeric Diagnosis | Secondary Numeric Diagnosis |

**Responsible Party**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (Last, First) | Age | Birth Date | Sex | Relationship to Patient   |
| Address (put same if same as above) | City | State | Zip Code | Marital Status |
| Employer | Home Phone | Cell Phone |

**Referring Provider (Doctor)**

|  |  |  |
| --- | --- | --- |
| Name(Last, First) | Phone | Fax |

**Primary Insurance Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Insurance Company | Policy Holder Name | Date of Birth and SS# | Policy Number |
| Insurance Address | City | State | Zip Code | Group Number |
| Phone Number | Co-Insurance % | Co-Pay | Deductible |

 **Secondary Insurance Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Secondary Insurance Company | Policy Holder Name | Date of Birth | Policy Number |
| Insurance Address | City | State | Zip Code | Group Number |
| Phone Number | Co-Insurance % | Co-Pay | Deductible |

|  |  |
| --- | --- |
| Signature of insured or authorized person | Date |