|  |  |
| --- | --- |
| |  | | --- | | **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 |