KIDSPLAY THERAPY CENTER, INC.

MALE () FEMALE ()

Client Information

Today's Date:

Child's Name: _____ DOB: _____
First Middle Initial Last

Parent (s)/Guardian(s): _____

Address: _____ City: _____ Zip: _____

Phone: Home _____ Work _____

Cell _____ Email _____

Does your child have an IEP? YES NO

Therapy: Speech () Occupational ()

Therapist _____

☐Please check if you do not want to receive group emails with our current programs and activities.

Person responsible for payment: _____ Social Security # _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Diagnosis: _____ ICD9: _____

Medicaid #:

Insurance Information

Insured Name: _____ DOB: _____
First Middle Initial Last

Employer: _____

Insurance Carrier: _____

ID #: _____ Group #: _____

Insurance Phone #: _____

Insurance Address: _____

Please list other insurance coverage: _____

_____

_____

Billing to: Parents Insurance Medicaid Other_____