Client Information Form – Adult

TODAY'S DATE _____ DATE OF BIRTH _____

NAME _____ ADDRESS _____

E-MAIL ADDRESS _____ _____

Check box next to preferred phone number

Phone (H)☐ _____ OCCUPATION _____

(W)☐ _____ EMPLOYER _____

(C)☐ _____ ADDRESS _____

_____

INSURANCE CO. _____ SECONDARY INSUR. CO. _____

ADDRESS _____ ADDRESS _____

_____ _____

GROUP # _____ ID# _____ GROUP# _____ ID# _____

INSURED'S NAME _____ INSURED'S NAME _____

SS# _____ SS# _____

ANY OTHER HEALTH BENEFIT PLAN?

_____

PERSON RESPONSIBLE FOR PAYMENT (PLEASE ADD ADDRESS IF DIFFERENT THAN ABOVE):

NAME _____ EMPLOYER _____

ADDRESS _____ INSURANCE CO _____

_____ GROUP# _____ ID# _____

PHONE: (H) _____ (W) _____ SS# _____

Your signature below authorizes COTI to release any &all pertinent information to your insurance company and physician to assist in claim approval.

SIGNATURE _____ Date _____

FAMILY HISTORY:

Adults in home _____ _____

Children in home _____ _____

_____ _____

MEDICAL BACKGROUND:

PRIMARY CARE PHYSICIAN_____

ADDRESS _____ CITY_____ STATE_____

ZIP_____ PHONE_____

OTHER PROFESSIONALS

NAME_____ NAME _____

ADDRESS_____ ADDRESS_____

CITY/ST/ZIP_____ CITY/ST/ZIP_____

PHONE_____ PHONE_____

SCHOOL (if currently a student)

School currently attending _____ Level_____

Accommodations or support in school or work

_____

OTHER ACTIVITIES

_____

_____

_____

PLEASE INDICATE BELOW POSSIBLE THERAPY TIMES IF INDICATED FROM THE EVALUATION.

Blue Ash only:

	MON	TUE	WED	THUR	FRI	SAT
8:30-12:30						
12:00-3:00						
3:00-6:00						