CLIENT INFORMATION FORM

TODAY'S DATE____________________ CHILD'S DATE OF BIRTH ______________________

CHILD'S NAME ____

INSURED PARTY_________________________	OTHER PARENT_________________________________
ADDRESS _______________________________	ADDRESS________________________________
____	____
CHECK BOX NEXT TO PREFERRED PHONE	*CHECK BOX NEXT TO PREFERRED PHONE*
PHONE ☐ (H) ____________________________	PHONE ☐ (H) ____________________________
☐ (W) _______________ EXT_________	☐ (W) __________________EXT_______
☐ (C) ____________________________	☐ (C) ____________________________
INSURED'S DOB _________________________	PARENT'S DOB __________________________
E-MAIL: _______________________________	E-MAIL: _______________________________
OCCUPATION_____________________________	OCCUPATION ____________________________
EMPLOYER ______________________________	EMPLOYER ______________________________
ADDRESS _______________________________	ADDRESS _______________________________
CITY/ST/ZIP ___________________________	CITY/ST/ZIP ___________________________
INSURANCE CO___________________________	SECONDARY INSURANCE CO___________________________
ADDRESS _______________________________	ADDRESS _______________________________
____	____
GROUP#_______ID#________________________	GROUP#_______ID#________________________
SS#_____________________________________	SS#_____________________________________

Any other health benefit plan? (i.e. Family Resources, etc.):

____

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____

I AM INTERESTED IN: ☐ Occupational Therapy ☐ Speech Therapy

WHAT IS THE CONCERN THAT BROUGHT YOU TO COTI:

___

FAMILY HISTORY:

Is your child adopted or fostered? ______

Adults in home ______ ______

Siblings & Ages ______ ______

______ ______

MEDICAL BACKGROUND:

Current Diagnosis (if any) ______

Medications currently taken ______

Allergies & Type of reaction ______

Seizures (past/present) ______

Special precautions ______

RELATED PROFESSIONALS:

PRIMARY CARE PHYSICIAN ______

SEND PROGRESS REPORTS ☐YES ☐NO

ADDRESS ______ CITY ______ STATE ______

ZIP ______ PHONE ______ FAX ______

OTHER PROFESSIONALS:

NAME ______ NAME ______

ADDRESS ______ ADDRESS ______

CITY/ST/ZIP ______ CITY/ST/ZIP ______

PHONE ______ PHONE ______

SEND PROGRESS REPORTS ☐YES ☐NO SEND PROGRESS REPORTS ☐YES ☐NO

SCHOOL

School currently attending ______ Grade ______

Contact Person ______ Title ______ Phone ______

Current school related services: (OT, Speech, Resource Teacher, etc):

______

OTHER ACTIVITIES (sports, music lessons, etc): ______

I would prefer: ☐ Blue Ash ☐ Anderson ☐ CCS in Fairfield
☐ MVCA(students only) ☐ 1st available

PLEASE INDICATE BELOW POSSIBLE THERAPY TIMES IF INDICATED AFTER EVALUATION.

	MON	TUES	WED	THURS	FRI	SAT
8:00-10:00						
10:00-12:00						
12:00-3:00						
3:00-6:00						