CLIENT INFORMATION FORM

TODAY'S DATE____________________ CHILD'S DATE OF BIRTH ______________________

CHILD'S NAME ____

INSURED PARTY__________________________

ADDRESS ________________________________

____

CHECK BOX NEXT TO PREFERRED PHONE

PHONE ☐ (H) ____________________________

☐ (W) _______________ EXT_________

☐ (C) ____________________________

INSURED'S DOB _________________________

E-MAIL: ________________________________

OCCUPATION______________________________

EMPLOYER _______________________________

ADDRESS ________________________________

CITY/ST/ZIP ___________________________

INSURANCE CO___________________________

ADDRESS ________________________________

____

GROUP#_______ID#________________________

SS#_____________________________________

OTHER PARENT__________________________________

ADDRESS__________________________________

____

CHECK BOX NEXT TO PREFERRED PHONE

PHONE ☐ (H) ____________________________

☐ (W) __________________EXT_______

☐ (C) ____________________________

PARENT'S DOB ___________________________

E-MAIL: ________________________________

OCCUPATION _____________________________

EMPLOYER _______________________________

ADDRESS ________________________________

CITY/ST/ZIP ____________________________

SECONDARY INSURANCE CO___________________________

ADDRESS ________________________________

____

GROUP#_______ID#________________________

SS#_____________________________________

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

____

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

NAME____________________________________

ADDRESS_________________________________

____

PHONE:(H)_________________ (W)_________

EMPLOYER________________________________

INSURANCE CO____________________________

GROUP#_______ID#________________________

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 ☐ 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						