CLIENT INFORMATION FORM

TODAY'S DATE: _____ CHILD'S DATE OF BIRTH: _____

CHILDS NAME: _____ FAMILY EMAIL: _____

INSURED PARENT/PARTY

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE NUMBER (please check box for preferred):

☐ HOME:_____

☐ CELL: _____

☐ WORK:_____

DATE OF BIRTH:_____

OCCUPATION:_____

EMPLOYER:_____

EMPLOYER ADDRESS:_____

CITY, STATE, ZIP:_____

***PRIMARY INSURANCE CO:**_____

INSURANCE CO. ADDRESS:_____

CITY, STATE, ZIP:_____

ID #:_____ GROUP #:_____

SSN:_____

OTHER PARENT/PARTY

NAME:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE NUMBER (please check box for preferred):

☐ HOME:_____

☐ CELL: _____

☐ WORK:_____

DATE OF BIRTH:_____

OCCUPATION:_____

EMPLOYER:_____

EMPLOYER ADDRESS:_____

CITY, STATE, ZIP:_____

***SECONDARY INSURANCE CO:**_____

INSURANCE CO. ADDRESS:_____

CITY, STATE, ZIP:_____

ID #:_____ GROUP #:_____

SSN:_____

Please list any other health benefit plan (i.e. family resources, etc.): _____

PERSON RESPONSIBLE FOR PAYMENT (ADD ADDRESS AND INSURANCE INFO IF DIFFERENT THAN ABOVE):

NAME:_____ EMPLOYER:_____

ADDRESS:_____ INSURANCE CO:_____

CITY, STATE, ZIP:_____ ID #:_____ GROUP #:_____

PHONE NUMBER: (H)_____ (C) _____

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

Signature: _____

PLEASE COMPLETE NEXT PAGE

I AM INTERESTED IN: ☐ Occupational Therapy ☐ Speech Therapy

WHAT IS THE MAIN CONCERN THAT BRINGS YOU TO COTI?: _____

_____

FAMILY HISTORY

Is your child adopted or fostered?_____

Adults in home:_____

Siblings & age:_____

MEDICAL BACKGROUND

Current diagnosis (if any):_____

Medications currently taken:_____

Allergies & type of reaction:_____

Seizures (past or present):_____

Special precautions:_____

RELATED PROFESSIONALS

Primary Care Physician:_____ Send reports? ☐ yes ☐ no

Address, City, State, Zip:_____

Phone #:_____ Fax #:_____

Other Professional Name(s): _____ Send reports? ☐ yes ☐ no

Address, City, State, Zip: _____

Phone #:_____ Fax #:_____ Specialty:_____

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 ☐ LGA *(students only)* ☐ CCS in Fairfield ☐ MVCA *(students only)*
☐ 1st available ☐ OVV *(students only)* ☐ Rockwern *(students only)*

PLEASE INDICATE YOUR PREFERENCE FOR WEEKLY APPOINTMENT TIMES
BY MARKING YES, NO, OR MAYBE IN THE BOXES BELOW:

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