

**CLIENT INFORMATION FORM**

TODAY'S DATE       CHILD’S DATE OF BIRTH

CHILD'S NAME       FAMILY E-MAIL

INSURED PARENT/PARTY OTHER PARENT

|  |  |
| --- | --- |
| NAME:       | NAME:       |
| ADDRESS:       | ADDRESS:       |
| CITY:       ZIP:       | CITY:       ZIP:       |

Check box next to preferred phone number

|  |  |
| --- | --- |
| PHONE [ ] (H)       | PHONE [ ] (H)       |
|  [ ] (W)      EXT       |  [ ] (W)      EXT       |
|  [ ] (C)       |  [ ] (C)       |
| DATE OF BIRTH:       | DATE OF BIRTH:       |
| OCCUPATION:       | OCCUPATION:       |
| EMPLOYER:       | EMPLOYER:       |
| ADDRESS:       | ADDRESS:       |
| CITY/ST/ZIP:       | CITY/ST/ZIP:       |
| INSURANCE CO:       | SECONDARY INSURANCE CO:       |
| ADDRESS:       | ADDRESS:       |
| CITY/ST/ZIP:       | CITY/ST/ZIP:       |
| GROUP#:       ID#:       | GROUP#:       ID#:       |
| SS#:       | SS#:       |

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

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

NAME:

ADDRESS:       CITY:       STATE:       ZIP:

|  |
| --- |
| PHONE: (H)      (W)      EMPLOYER:       |
| ADDRESS:       CITY:       STATE:       ZIP:        |
| INSURANCE CO:       |
| ADDRESS:       |
| CITY/ST/ZIP:       |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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/present)

Special precautions

**RELATED PROFESSIONALS:**

**PRIMARY CARE PHYSICIAN** Send progress reports [ ] yes [ ] no

ADDRESS       CITY      STATE     ZIP       EMAIL:

PHONE

**OTHER PROFESSIONALS:**

NAME       SPECIALTY

ADDRESS       CITY      STATE     ZIP

PHONE

NAME       SPECIALTY

ADDRESS       CITY      STATE     ZIP

**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 [ ]  OVV

 [ ]  MVCA (students only) [ ]  LGA

 [ ] 1st available [ ]  Rockwern

**PLEASE USE THE PULL DOWN MENU TO INDICATE BELOW YOUR PREFERENCE FOR THERAPY TIMES (FOR EVALUATION AND TREATMENT IF INDICATED):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | MON | TUES | WED | THURS | FRI | SAT |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 8:00-10:00 |  |  |  |  |  |  |
| 10:00-12:00 |  |  |  |  |  |  |
| 12:00-3:00 |  |  |  |  |  |  |
| 3:00-6:00 |  |  |  |  |  |  |