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:

☐ 1st Available
☐ Blue Ash
☐ CCS in Fairfield
☐ Presbyterian Preschool
☐ Rockwern (students only)
☐ OVV(students only)
☐ St.Rita(students only)
☐ CHDS(students only)
☐ 7Hills(students only)
☐ CCDS(students only)
☐ MVCA(students only)

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	yes	yes	yes	yes	yes	yes
10:00-12:00	yes	yes	yes	yes	yes	yes
12:00-3:00	yes	yes	yes	yes	yes	yes
3:00-6:00	yes	yes	yes	yes	yes	yes