



CLIENT INFORMATION FORM

TODAY'S DATE: _____

CHILD'S DATE OF BIRTH: _____

CHILD'S 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

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: ☐ 1st available ☐ Blue Ash ☐ CCDS (*students only*) ☐ St. Rita (*students only*)

☐ Summit Academy (*students only*) ☐ New School Montessori (*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
8:00-10:00					
10:00-12:00					
12:00-3:00					
3:00-6:00					