OUTPATIENT THERAPY CENTER

653 Town Center Drive #117, Las Vegas, NV 89144
Main # (702) 233-7470   Fax # (702) 233-7426

PEDIATRIC PATIENT INFORMATION

Name________________________________ Social Security______________

Date of birth____________________ Age ______ ❑ Male ❑Female

Street Address____ Apt. # ________

City________________________ State ______ Zip________ Phone # __________

Parent/Guardian ____

Phone # __________________ Work#________________ Email_______________

Emergency Contact __________________________ Phone # ________________

Appointment reminder preference: ❑ Email ❑ Phone Call ❑ Text Message ❑ No Reminder

INSURANCE INFORMATION

Primary Insurance______________________ Responsible Party Name_______________

Date of birth____________________ Social Security______________________

Employer Name____________________ Phone # ______________ Ext.________

Title ________________________________

Secondary Insurance ____________________ Responsible Party Name_______________

Date of birth____________________ Social Security______________________

Employer Name____________________

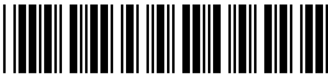
Title ________________________________

PHYSICIAN INFORMATION

Referring Physician ________________________ Phone # ____________________

Treatment Diagnosis____

BAR CODE



HP1024

PEDIATRIC PATIENT HISTORY

(PMM# 78290251) (R 4/21) (FOD)

PATIENT IDENTIFICATION

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Medical History:

Has your child had any surgeries? ❑Yes ❑No

If yes, please list with dates:

____

____

Is your child taking any medicine? ❑Yes ❑No

Please list: ____

Is your child allergic to foods, medicine, or otherwise? ❑Yes ❑No

Please list all allergies: ____

Birth History:

Weight of your baby at birth _______ lbs.

Was your child ❑full term ❑premature?

How many weeks gestation? __________

Were there any problems during pregnancy? ❑Yes ❑No

If yes, please describe: ____

Were there any problems immediately after birth? ❑Yes ❑No

Please describe: ____

Developmental History (please indicate age):

Bladder/Bowel control _____ Self-dressing _____ Standing alone _____

Crawling _____ Sitting unsupported _____ Walking _____