Patient Face Sheet

Patient Name: ____DOB: ________________

Mother's Name: ____

Father's Name: ____

Address: ____

City: ____________________________________ Zip Code: ____________________________

Phone #: Home: ____

Mom Cell# _______________________________Dad Cell#_____________________________

Mom Work# ______________________________Dad Work#_____________________________

E-Mail Address: ____

Would you like to be included in our Parent Connection to receive information about upcoming events, hot topics, and activities: Y or N

Emergency Contact: Name: ____

Phone# ____

Diagnosis: ________________________________Medications:__________________________

Allergies: ________________________________ Diet Restrictions_______________________

Sensory Aversion/Triggers:__________________ History of Seizures: Y or N

Does your child receive any other services? If so, please list:____________________________

Primary Care Physician: ____________________Physician Phone #: ______________________

Insurance Company: ____

Referred By: ____

I confirm that all of the above information is accurate, and I agree to notify Thrive Therapy Associates, LLC of any changes.

____ **Date:** _______________

Parent or Guardian Signature

Office use only ICD-10 Code(s): ____