Bartlesville Hope
Pediatric Therapy

117 W. 5th Street
Bartlesville, OK 74003
Phone: 918-203-3313
Fax:918-512-4082

New Patient Form

Date:_____ Referred By:_____

Patient's Name:_____ DOB:_____

Age:_____ Sex:____ Home Phone:_____ Cell Phone:_____

Street Address:_____

City/State/Zip:_____

Email:_____

Responsible Party: Father_____ Mother_____ Other_____

Responsible Party Name:_____

Street Address:_____

City/State/Zip:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Emergency Contact:_____ Relation:_____

Phone:_____

Primary Care Physician:_____

Location:_____ Phone:_____

Fax:_____ Date last seen b

PCP:_____. Diagnosis:_____

Please Indicate if Your Child Has Received therapy services within the past 12 months

0. Physical Therapy: Date of Last Eval:_____ Clinic:_____

0 Occupational Therapy: Date of Last Eval:_____Clinic:_____

0 Speech Therapy: Date of Last Eval:_____ Clinic:_____

INSURANCE INFORMATION (Please furnish a copy, front & back, of your insurance card)

Primary Insurance_____

Insured's Name_____. DOB_____ SSN_____.

Group#_____ ID#_____

Secondary Insurance:_____

Insured's Name_____ DOB_____ SSN_____

Group#_____ ID#_____

Payment Method for COINSURANCES, COPAYS, or Deductibles:

FSA Card_____ HSA Card_____

Credit Card_____

Debit Card_____

Cash_____

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT:_____

**Please sign and consent for treatment and financial policy form as well.