EAT TALK PLAY
THERAPY LLC

New Patient Intake Form

Patient Name: ____

Date of Birth: ______________________

Referred by Doctor/Professional (if applicable): ________________________________

Diagnosis (if applicable): ____

Primary Area of Concern and Describe concern (feeding, speech, language, play, etc.): __________

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Family Information:

Parent/Guardian Name: ____________________________________

Relationship: ______________________

Parent/Guardian Name: ____________________________________

Relationship: ______________________

Primary Address of Patient: ____

Primary Phone Number: ________________________ Type: Cell Work Home

Secondary Phone Number: ______________________ Type: Cell Work Home

Primary Email Address: ________________________ Type: Personal Work

Secondary Email Address: ______________________ Type: Personal Work

Who will be the primary person bringing your child into therapy? ______________________

What are your preferred days and/or times for making appointments? ____________________

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**Emergency Contact: ___________________________ Phone: _____________

Relationship: ______________________

Insurance Information:

Will you be seeking reimbursement from insurance (circle)? Yes No

If yes, please provide your insurance providers' information:

Provider: ______________________ Policy Number: ______________

Primary on Account: ______________________ Group Number: ______________

Primary on Account Date of Birth: ______________ Social Security #: ______________

Secondary Insurance (if applicable):

Provider: ______________________ Policy Number: ______________

Primary on Account: ______________________ Group Number: ______________

Primary on Account Date of Birth: ______________ Social Security #: ______________

Credit Card Information:

Credit Card Number: ______________________ Expiration Date MM/YY: __________

Type (circle): Visa Mastercard Discover American Express CVC #: __________

*Note: ***Eat, Talk & Play Therapy LLC*** will only charge credit card in the event of violation of attendance policy, or with prior approval from parent/guardian.

Please FAX or EMAIL this completed form to ***Eat, Talk & Play Therapy LLC***.

You will be contacted within 24-48 hours to schedule your appointment.

FAX: 480.274.9718

Email: eattalkandplaytherapy@gmail.com