WELCOME TO:

Office Use Only

Diagnosis: ______

The Therapy SPOT for Pediatric & Adult
Speech Physical Occupational Therapy, PLLC
1770 Motor Parkway- Suite 202
Islandia, NY 11749
(631)582-0088

Thank you for choosing our office.
In order to serve you properly we will need the following information. All information will be strictly confidential.

Patient's Name:		**Circle:** M F	**Birthdate:**	**Martial Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Address:		**City**	**State** **Zip**	**Home Phone:**
If child, parent's or guardian's name:		**Occupation:**	**Business Phone:**	**Cell Phone:**
Do you have medical insurance? ☐ Yes ☐ No	**If no, how do you intend to pay?** ☐ Check ☐ Cash ☐ Credit Card		**Primary Insurance Company:**	
Subscriber Name:		**Insured's Birthdate:**	**Policy Number:**	
Secondary Insurance Company/Subscriber Name/Policy Number:				
Person Financially Responsible for this account:			**Relationship to Patient:**	
Whom may we thank for referring you?				

REQUEST FOR RELEASE OF INFORMATION:

I authorize The Therapy SPOT, PLLC to send the listed report(s)/information to the following:

☐ Yes ☐ No

Report(s)/information to be sent: Evaluation and/or ________________________________

Please send to: (list name and address/phone number)

______

______

______

Patient, Parent, or Guardian Signature: **Date:**