

PATIENT APPLICATION FORM
461 West Huron St. - Suite 406, Pontiac, MI 48341
1-888-875-6662 - Fax: 248-857-7102
www.europeds.org

***PLEASE FILL OUT THIS APPLICATION COMPLETELY. ANY UNANSWERED QUESTIONS WILL DELAY THE APPLICATION PROCESS. THANK YOU.**

CHILD'S NAME: _____ DATE OF APPLICATION: _____

DATE OF BIRTH: _____ AGE: _____ M: ___ F: ___

PARENT/GUARDIAN NAMES: _____

ADDRESS: _____

PHONE #: HOME _____ CELL _____

WORK _____ E-MAIL: _____

1. WHAT ARE THE CHILD'S DIAGNOSES: _____

2. WHAT IS THE CHILD'S HEIGHT: _____ WEIGHT: _____

3. CURRENT MEDICATIONS (Also include reason for taking): _____

4. PLEASE PROVIDE PHONE NUMBERS TO SPECIALISTS WHO TREAT YOUR CHILD: _____

CHILD'S NAME: _____ DOB: _____

5. PAST MEDICAL HISTORY: _____

PLEASE INDICATE IF YOUR CHILD HAS A HISTORY OF THE FOLLOWING (DESCRIBE):

YES NO

- SEIZURES (How often/date of last occurrence?): _____
- SCOLIOSIS (What degree of scoliosis?): _____
- HIP SUBLUXATION (What %?): _____
- FRACTURES: _____
- VISION/HEARING PROBLEMS: _____
- VENTRICULOPERITONEAL SHUNT (Hydrocephalus): _____
- GASTROINTESTINAL TUBE (G-Tube): _____
- TRACHEOSTOMY TUBE (Trach): _____
- BOTOX/PHENOL INJECTIONS: _____
- HEART, LUNG, KIDNEY, DIABETES, etc: _____

CHILD'S NAME: _____ DOB: _____

6. **SURGICAL HISTORY** (muscle or tendon lengthening/releases, selective dorsal rhizotomy, baclofen pump, spinal fusion/rods, osteotomy, reconstructive joint surgeries, etc): _____

7. **HAS YOUR CHILD RECEIVED OTHER PHYSICAL THERAPY SERVICES THIS POLICY YEAR?**
(If yes, how often and where? This helps us determine tolerance to therapy and also insurance coverage) _____

8. **PAST & CURRENT MEDICAL EQUIPMENT** (braces, walker, crutches, wheelchair, etc): _____

9. **CHILD'S ABILITIES** (rolling, sitting, crawling, walking, etc): _____

10. **HOW DO YOU COMMUNICATE WITH YOUR CHILD/HOW DOES HE OR SHE COMMUNICATE WITH YOU?** _____

11. **IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS?** _____

12. **HAVE YOU EVER BEEN DENIED THERAPY AT EURO-PĒDS? (If yes, please explain)** _____

13. **HAS YOUR CHILD RECEIVED THEIR IMMUNIZATIONS? (If no, please explain):**

CHILD'S NAME: _____ DOB: _____

14. HOW DID YOU HEAR ABOUT EURO-PEDS? _____

15. REFERRING PHYSICIAN: _____

ADDRESS: _____

PHONE: _____ FAX: _____

LICENSE #: _____ EXP DATE: _____ NPI #: _____

***If you would like to participate in SUIT THERAPY, please know that there will be 1-2 additional steps to take. Once your child is approved for Intensive PT and his/her session is scheduled, your child will need to have Hip X-rays taken within 6 months of his/her admission. Those X-ray films will then need to be brought to Euro-Pēds your first day (unless notified otherwise) to determine if your child is a candidate for Suit Therapy. If there is a possibility of scoliosis or other spinal abnormalities, spinal X-rays within 6 months of admission will also be needed.**

INSURANCE INFORMATION:

1. PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMPLOYER: _____ PROVIDER PHONE #: _____

CONTRACT #: _____ GROUP #: _____

2. SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER: _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMPLOYER: _____ PROVIDER PHONE #: _____

CONTRACT #: _____ GROUP #: _____