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 #: _____