BIG BLUE CANOPY
PEDIATRIC GYM & THERAPY SERVICES

Patient Information

Child's full name: _____ Child's preferred name (nickname): _____

Date of Birth: _____ Age : _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Is the patient a foster child? Yes/ No : _____

Case Worker Name: _____ Phone: _____ County: _____

Additional information regarding care, contact, and restrictions: _____

Whom may we thank for referring you to our office?: _____

Guardian Information

Guardian Name (1): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Guardian Name (2): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Physician Information :

Physician/ Pediatrician(Name and Facility): _____

Physician Phone number : _____ Physician Fax Number: _____

Insurance Information :

Please list all the insurance plans for which the patient is a beneficiary.
If your child is covered by CareSource,Buckeye Community plan, Molina, UNC Community Plan, Paramount, or Medicaid, please list any and all commercial insurance policies that list your child as beneficiary in order to ensure that all claims are processed appropriately.

Primary Insurance:

Policy Holders Name: _____ DOB: _____

SSN: _____ Employer: _____

Insurance Company Name & Address:

_____

Phone: _____ ID#: _____ Group: _____

Secondary Insurance:

Policy Holders Name: _____ DOB: _____

SSN: _____ Employer: _____

Insurance Company Name & Address:

_____

Phone: _____ ID#: _____ Group: _____