JMU Occupational Therapy Clinical Education Services

Face Sheet

CLIENT INFORMATION DATE: _____

Name:_____ Sex (circle one): M or F

Birth date:_____ Age:_____

PARENT/GUARDIAN INFORMATION (responsible party)

Name:_____ Relationship:_____

Address(es):_____

_____

Phone:_____ E-mail:_____

Preferred method of contact (circle): Call Text E-mail Either

Best time(s) to contact:_____

INSURANCE PROVIDER/PLAN INFORMATION (check all that apply):

☐ No Insurance/Private Pay ☐ Please provide copy of Insurance Card

	Primary	Secondary
Name of Plan Provider		
Policy Holders: Name, DOB, SS#		
Policy/ID #		
Group # (if applicable)		
Phone #: Provider Services		

Please List Child's Current Physician and Practice:

_____

_____

_____

☐ Please check here if you authorize our clinic to contact your physician/practice to request updated prescriptions/referrals. If you do not check, you will be responsible for requesting this information.

Medication Changes/Allergies: (please update as needed): _____

_____

_____