

Play and Learn Pediatric Occupational Therapy Intake

Child's Name	Date of Birth	M	F
		Sex	
Parent's/Guardian's Name	Parent's/Guardian's Name		
() _____	() _____	() _____	() _____
Home Phone	Work/mobile Phone	Home Phone	Work/mobile Phone
Address	Address		
City, ST ZIP Code	City, ST ZIP Code		

Emergency Contacts

Referring Contact

Primary Emergency Contact/Phone Number	Referring Therapist or Doctor/Phone Number
Address	Address
City, ST ZIP Code	City, ST ZIP Code

School and Medical Contact Information

Name of School	Phone Number
Teacher's Name	Phone Number
Physician's Name	Phone Number
Allergies/Special Health Considerations	

I agree to pay my occupational therapy bill to Beverly W. Burnett/ Play and Learn Pediatric Occupational Therapy **IN FULL** by the end of the first week of every month. I also agree to pay for cancellations in full unless I have given a 48 hr. notice or an emergency prevented me from giving such notice (illness, accident, etc.) I have also read and agree to all of the Play and Learn Policies.

Parent's/Guardian's Signature	Date
Witness Signature	Date