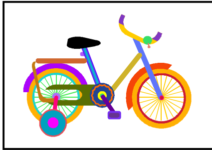

Training Wheels
Occupational Therapy
1360 South St
Portsmouth NH 03801
603.501.0897

PATIENT'S NAME____ DATE______________________
(LAST) (FIRST) (MI)

ADDRESS____
(STREET) (CITY) (STATE) (ZIP)

HOME PH#_________________________ SEX______ DATE OF BIRTH______________ SS#___________________________

PRIMARY CARE PHYSICIAN_______________________________PHYSICIAN PHONE#_____________________________

INSURED'S NAME _____________________________SS#________________________ HOME PH#___________________

DATE OF BIRTH________________ EMPLOYER________________________________ CELL PH#____________________

SPOUSE NAME____________________________ HOME PH# (if different)_________________ CELL PH#_______________

EMERGENCY CONTACT _____________________ ADDRESS_______________________ PHONE #____________________

REFERRED BY ____ PHONE#____________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY____ PHONE#__________________________

BILL ADDRESS______________________________________ CITY ___________________ STATE ______ ZIP ____________

INSURED'S NAME ____ ID# _______________________________

GROUP # _________________________________ HMO ________ PPO _______ PAYOR ID # __________________________

DEDUCTIBLE AMOUNT ________ AMOUNT MET________ TYPE POLICY____________ CO PAY AMOUNT __________
(100%, 80/20, ETC.)
MAX VISITS ________ VISITS MET ________ POLICY PERIOD______________ AUTHORIZATION NEEDED__________

EXCLUSIONS/LIMITATIONS____
INSURANCE REP'S NAME _____________________________ CONFIRMATION # __________________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY____ PHONE#__________________________

BILL ADDRESS______________________________________ CITY ___________________ STATE ______ ZIP ____________

INSURED'S NAME ____ ID# _______________________________

GROUP # _________________________________ HMO ________ PPO _______ PAYOR ID # __________________________

DEDUCTIBLE AMOUNT ________ AMOUNT MET________ TYPE POLICY____________ CO PAY AMOUNT __________
(100%, 80/20, ETC.)
MAX VISITS ________ VISITS MET ________ POLICY PERIOD______________ AUTHORIZATION NEEDED__________

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: **TRAINING WHEELS OCCUPATIONAL THERAPY LLC**

____
(SIGNATURE OF PATIENT OR PARENT)