TheraPlay at Home
Mailing: 113 W. Chapman Rd, Oviedo, FL 32765

info@theraplayathome.com
PHONE 407-790-5601
FAX 407-602-7858

Patient

Name (Last, First)	Age	Birth Date	Sex
Mailing Address	City	State FL / Zip Code	County
Primary Diagnosis:	Primary Numeric Diagnosis (from prescription)	Secondary Numeric Diagnosis (from prescription)	

Responsible Party

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
Email:	Home Phone	Cell Phone		

Doctor

Name (First and Last) Practice Address:	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %		Co-Pay	Deductible

Secondary Insurance Information or PLSA Grant ID #

Secondary Insurance Company	Policy Holder Name		Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %		Co-Pay	Deductible

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Therapy Location:

Home:	
School / Daycare:	
Office: 113 W. Chapman Rd, Oviedo	
Other, please state:	

Time or days you prefer (please list specific times if you have little flexibility):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
After School							
PM							

Type of therapy you are requesting:

Physical Therapy	Occupational Therapy	Speech Therapy

I have listed all insurance coverage. Signature of insured or authorized person	Sign & Date

Administrators Notes: