



Dragonfly Pediatric Therapy, Inc.
13003 Camden Circle SE
Huntsville, Alabama 35803
Phone: 256-797-6001

Parent Information (please print)

Gaurdian: _____ Address: _____
City/State/Zip: _____
Home Phone#: _____ Alternate Phone#: _____
Email Address: _____ Preferred Contact: Phone or Email
Referring Physician/Pediatrician Name: _____
Physician's Phone#: _____ Physician Fax#: _____
How did you hear about us? _____

Patient Information

Child's Full Name: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
Age: _____ Sex: M F How many siblings? _____
Birth order? _____ Diagnosis: _____

Insurance Information (Please fill out in full and sign so claims can be sent to your insurance company.)

Policy Holder's Name: _____
Policy Holder's Employer: _____
Insurance Company: _____
Insurance Company Address: _____ Phone#: _____
Policy Holder's Date of Birth: _____
Policy Holder's Social Security#: _____
ID#: _____ Group#: _____

Secondary Insurance Information (if applicable)

Policy Holder's Name: _____
Policy Holder's Employer: _____
Insurance Company: _____
Insurance Company Address: _____ Phone #: _____
Policy Holder's Date of Birth: _____
Policy Holder's Social Security#: _____
ID#: _____ Group#: _____

AUTHORIZED PERSON'S SIGNATURE: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Dragonfly Pediatric Therapy, Inc. A photocopy of this assignment is to be considered as valid as an original. I authorize Dragonfly Pediatric Therapy, Inc. to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed: _____ Date: _____