9141 Cypress Green Drive, Ste 2
Jacksonville, FL 32256
(904) 647-1849
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Pediatric Patient Profile

Contact Information

Patient First Name		**Patient Last Name**	
DOB		**Patient SSN**	
Sex		**Preferred Language**	
Primary Address			
Secondary Address			
Mother's First Name		**Mother's Last Name**	
Father's First Name		**Father's Last Name**	
Primary Phone Number		**Secondary Phone Number**	
Primary Email Address			
Secondary Email Address			

Emergency Contact Information: ***At least one emergency contact person must be listed with contact information***

First and Last Name	Relationship to patient	Phone Number	Home Address

Insurance Information

Primary:

Insurance Provider		**Plan Type**	
Group Number		**Policy Number**	
Policy Holder First Name		**Policy Holder Last Name**	
Policy Holder SSN		**Policy Holder DOB**	

Does the Insurance cover ABA services?	**Yes**	**No**	**Unknown**
Does the Insurance cover OT services?	**Yes**	**No**	**Unknown**
Does the Insurance cover SLP services?	**Yes**	**No**	**Unknown**

Secondary:

Insurance Provider		**Plan Type**	
Group Number		**Policy Number**	
Policy Holder First Name		**Policy Holder Last Name**	
Policy Holder SSN		**Policy Holder DOB**	

Does the Insurance cover ABA services?	**Yes**	**No**	**Unknown**
Does the Insurance cover OT services?	**Yes**	**No**	**Unknown**
Does the Insurance cover SLP services?	**Yes**	**No**	**Unknown**

Physician Information

Referring Physician Name	Practice Name	Office Phone Number

Please list all current Physicians, Specialists, or Therapists

Physician or Clinician	Practice Name	Phone Number

Please list all previous Physicians, Specialists, or Therapists

Physician or Clinician	Practice Name	Phone Number

***** *Please provide any and all necessary diagnostic paperwork, testing, and IEPs from other providers or academic institutions. This paperwork is often necessary for authorization of services from most insurance companies.*

Medical Information

Medical and Psychological Diagnoses

Diagnosis	Date of Diagnosis	Diagnosing Physician	Physician Phone Number

Birth Order of Patient		What if any, medications were taken during pregnancy?			
Length of pregnancy		Breech birth?			
Caesarian?		Convulsions at birth?			
Breathing difficulty at birth?		Other problems at birth?			
Injuries at birth		Birth weight		Apgar Score	
Breast fed? If yes, how long?		Child sat alone at how many months?		Child walked alone at how many months?	
Feeding difficulties?		Any hospitalizations or surgeries?			
Was rate of growth normal?		General development up to the age of 3?			
Swallowing difficulties?		Slow Average Rapid			
Did child control body movements?		Is the child Curious?		General Health Good Fair Poor	

Any history of ear infections?		**First words at how many months?**		**Put words together at how many months?**	
Does the child have any vision problems? If so, do they wear glasses?		**Date of last vision screening**		**Date of last hearing test**	
Any family members with hearing problems?					
Relationship: _____ Age: _____					

Allergy/ Medical Alert Information

Tree or Nut Allergies	**Yes No**	**Epi-pen Prescription**	**Yes No**

Please list all other allergy information below

Allergy	Reaction	Severity on Scale of 1-10	Allergy Medication Prescribed

Please list any and all medical alerts *(e.g., seizure disorders, elopement risk, diabetes, etc.*) and corresponding precursor symptoms/behaviors if applicable:

Medical Alert	Medications or safety equipment/safety plans

Current Medications and Dosages:

Medication	Dosage	Dosing Frequency

Medications Continued

Psychosocial Family History:

Please list any family history of developmental delay, neurological disorders, psychological disorders, or other relevant diagnoses

Family Member	Diagnosis	Are they currently taking medications or in treatment for the diagnosis?

Language

Primary language of the patient	
Primary language of caregivers	
Does the patient live in a bilingual household? If yes what languages	

Please describe your primary concerns below:

Please use the table below to tell us about the patient's current schedule, including school, other therapies, extracurricular activities, occupation, etc. so that we know your availability for therapy.

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8am					
9am					
10am					
11am					
12pm					
1pm					
2pm					
3pm					
4pm					
5pm					
6pm					

Release and Statement to Permit Payment of Private Insurance Benefits to the Provider(s)

I _____, herby authorize Bloom Behavioral Solutions, Inc. and its employees to contact my insurance company to verify benefits for _____. I authorize the release of medical information as necessary to assist in the payment of any third party, or insurance company, and that payments be made directly to Bloom Behavioral Solutions, Inc. for any services rendered to the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. The signature furnished below shall suffice for all insurance forms from this date forward.

_____ _____

Signature of Responsible Party **Date**

Consent for Treatment

I, _____ consent to, and authorize the performance of any assessments, evaluations, and intervention procedures, as deemed medically necessary by any clinician to provide initial, and ongoing effective treatment to _____. I understand that to update plans of care, additional testing or assessments may be required at any time during treatment.

_____ _____

Signature of Responsible Party **Date**

Agreement to Pay for Treatment

I, _____agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance benefits that cover the services rendered, I agree to pay all applicable co-payments, co-insurance and deductibles. I further understand that **I am 100% responsible for all fees at the time services are rendered**, **and that verification of benefits is not a guarantee of payment**. In the event that my health insurance does not cover rendered treatment, I am financially responsible for all services.

I authorize that all the information provided is accurate and true. Should any of the information change, including but not limited to, diagnoses, medication, allergy and medical alerts, insurance benefits, etc. it is my responsibility to provide the updated information to Bloom Behavioral Solutions, Inc.

_____ _____

Signature of Responsible Party **Date**

Office Use Only:

Name of office staff as witness: _____

Title/Position: _____

Signature of office staff as witness: _____ **Date Entered:** _____