Children's Program – Outpatient Services Intake Form

Today's Date: _____/_____/_____

CHILD'S INFORMATION

First Name: _____ Middle Initial: _____

Last Name: _____

Date of Birth: _____ Gender: M / F Race/Ethnicity: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1

First Name: _____ Last Name: _____

Relationship to Child: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone number: _____

Parent/Guardian #2:

First Name: _____ Last Name: _____

Relationship to Child: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone number: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship to Child: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone number: _____

CHILD'S MEDICAL INFORMATION

Child's vision diagnosis: _____

Primary Care Provider

Name: _____

Phone: _____

Clinic Location: _____

Eye Doctor

Name: _____

Phone: _____

Clinic Location: _____

Are you connected with the Special Needs Clinic at Children's Hospital of Wisconsin?

YES / NO / UNSURE, I would like more information

Do you have a Care Coordinator at the Special Needs Clinic?

YES / NO

If yes, please provide their name and contact information:

Name: _____ Phone number: _____

Is your child currently taking any medications? YES / NO

List: _____

_____

_____

Does your child have any allergies? YES / NO

List: _____

Does your child suffer from seizures? YES / NO

How often?_____

INSURANCE INFORMATION

Primary Insurance

Name of insurance: _____

Policy number: _____

Group number: _____

Name of subscriber: _____

DOB of subscriber: _____

Secondary Insurance

Name of insurance: _____

Policy number: _____

Group number: _____

Name of subscriber: _____

DOB of subscriber: _____

THERAPY SERVICES

What services are you currently interested in for your child?

Physical Therapy Occupational Therapy Speech Therapy Music Therapy

Is the child currently receiving medically based therapies in a private clinic, school, or elsewhere? YES / NO

If so, where? _____

Clinic/School contact number: _____

What times do not work for appointments?_____

(*please note that we will do our best to accommodate schedules, but this is based upon availability)

How did you hear about Vision Forward? _____