



Information in this form can be shared with:

- Cobblestone Therapy Group, LLC
- Key Music Center, LLC

- Jacob's Ladder School and Therapy Center

Patient Information Form

NEW INFORMATION!

Patient's Name (as appears on insurance card): _____ DOB: _____

Male / Female Parents' Names: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ *Please circle preferred method of communication.

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Other doctors and specialists who is involved in your child's care:

Name	Specialty	Phone Number

How did you hear about The George Center? _____

NEW INFORMATION!

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured SS #: _____ Insured's D.O.B: _____ Employer's Name: _____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____

Cust Service #: _____

Has your child been approved for the Georgia NOW/COMP Waiver?

I understand and agree to the George Center for Music Therapy, Inc., Notice of Privacy Practice.

Signature: _____ Date: _____



NEW INFORMATION!
Family Background

Mother's Name: _____ Age: _____

Occupation: _____

Father's Name: _____ Age: _____

Occupation: _____

Marital Status: Single Married Divorced Separated Widowed

Languages Spoken at Home (circle primary): _____

Is your child adopted? Yes No

Brother(s) and/or Sister(s) of the child:

Name	Age

What are your priorities in coming to The George Center?

Does your child currently receive other therapy services? Yes No

If "Yes", where and when? _____

NEW INFORMATION!
Medical History

At how many weeks was your child born? _____ Birth weight? _____

Were there any complications during the pregnancy or delivery? Yes No Please describe: _____

Was your child hospitalized after birth? _____



Does your child have any other medial issues? _____

Please list any hospitalizations and/or medical procedures your child has received: _____

Current medications:

Name	Dosage	Frequency	Reason for medication

Any known allergies? Yes No. If yes, please describe: _____

Any diet restrictions? Yes No. If yes, please describe: _____

Education Information

Is your child currently enrolled in school? Yes No

If "Yes", where and days attended: _____

Does your child receive any services through the school? Yes No

If "Yes", what services? _____

Does your child have a current Individualized Education Plan (IEP)? Yes No

Social/Emotional History

What are your child's favorite toys/activities? _____

What are your child's favorite songs? _____

What typically calms/soothes your child? _____

Is your child currently enrolled in any community activities (music class, play groups, Mother's Morning Out, Miracle League, Aquatic Lessons)? _____

Anything else you would like to tell us about your or family? _____

PARENT/GUARDIAN SIGNATURE

DATE

PRINTED NAME

RELATIONSHIP TO CHILD