Child's Name: (Last) ________________________ (First) ______________________ (MI) ________

Nickname:_________________________ Date of Birth: ____________________ Male Female

Home Address: ____

City: _________________________________ State: ________________________ Zip: ___________________

Primary Diagnosis: ____

Additional Diagnoses: ____

Child Resides With: Both Parents Mother Father Other relative:_____________________________________

PARENT INFORMATION

Parent 1/Guardian Name:____

Relationship to Child: ____

Date of Birth: _________________ Email Address: ____

Home Phone: ________________________________ Mobile Phone: ___________________________________

Occupation: _____________________________________Employer: ____________________________________

Parent 2/Guardian Name:____

Relationship to Child: ____

Date of Birth: _________________Email Address: ____

Home Phone: _________________________________Mobile Phone: ____________________________________

Occupation: ____________________________________Employer: _________________________________

CONSENT TO TREAT

Dynamic Pediatric Speech Therapy, LLC recognizes that parents may sometimes rely upon other family members or caregivers to transport their child to therapy or be home with their child during therapy sessions. Please list all family members and/or caregivers in whose presences *Dynamic Pediatric Speech Therapy, LLC* has your expressed permission to treat your child, as well as discuss your child's treatment of that day, in your absence.

Name: ____________________________________Relationship: _______________________________________

Name: ____________________________________ Relationship: ______________________________________

Name: _____________________________________ Relationship: _____________________________________

Signature of Parent/Legal Guardian: ____ Date: _______________

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