



2846 Brandt Drive South  
Fargo, North Dakota 58104  
p: 701.232.2340  
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PediatricTherapyPartners.com

**Parent/Guardian Request Form for Services**

Patient First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Medical Provider: \_\_\_\_\_ Location of Provider: \_\_\_\_\_

Diagnosis/Concerns: \_\_\_\_\_

Parent(s)/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_ How did you hear about PTP? \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

I would like my child to be evaluated for the following  OT  PT  SLP  Not Sure

I am particularly concerned about my child's:

- |                                         |                                          |                                        |                                            |
|-----------------------------------------|------------------------------------------|----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Balance        | <input type="checkbox"/> Grasping        | <input type="checkbox"/> Social Skills | <input type="checkbox"/> Walking           |
| <input type="checkbox"/> Writing        | <input type="checkbox"/> Communication   | <input type="checkbox"/> Dressing      | <input type="checkbox"/> Feeding           |
| <input type="checkbox"/> Sitting        | <input type="checkbox"/> Stuttering      | <input type="checkbox"/> Coordination  | <input type="checkbox"/> Clarity of Speech |
| <input type="checkbox"/> Attention Span | <input type="checkbox"/> Number of Words | <input type="checkbox"/> Other: _____  |                                            |

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

**Fax form to 701-232-2330 or mail to Pediatric Therapy Partners 2846 Brandt Dr S, Fargo, ND 58104**