AchieveCenter
PEDIATRIC THERAPY

Patient Information Form - 1 of 2

PN	Last, First Initial (Office Use Only)

Patient Information

Name:		DOB:
Phone:	Email:	
Mailing Address:		Gender : Male Female
City, State:	Zip:	Language : English Spanish
Referring Physician:	Phone:	
Primary Care Physician:	Phone:	
Known Allergies / Precautions:		

Parent / Guardian Name(s)

Name:	Email:
Home Phone:	Cell Phone:
Name:	Email:
Home Phone:	Cell Phone:

Emergency Contact Information

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Caregiver Name(s) *People who might bring patient to appointments*

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Spokane
528 E. Spokane Falls Blvd., Ste 401
Spokane, WA 99202
P: **509-435-0481**
F: **509-435-0485**

Moses Lake
2323 W. Broadway Ave., Ste 3
Moses Lake, WA 98837
P: **509-707-0336**
F: **509-707-0341**

Tri-Cities
7203 W. Deschutes Ave., Ste A
Kennewick, WA 99336
P: **509-619-7397**
F: **866-798-0203**

Wenatchee
1500 S. Mission St.
Wenatchee, WA 98801
P: **509-888-2505**
F: **509-888-2507**

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Patient Information Form - 2 of 2

Primary Insurance Information

Primary Insurance:		
Member ID:	Group #:	
Patient's Relationship to Subscriber (i.e. self, child, spouse):		
If other than "self", enter information below for subscriber		
Subscriber Name:	DOB:	Gender : Male Female
Mailing Address:		
City, State:	Zip:	

Secondary Insurance Information

Secondary Insurance:		
Member ID:	Group #:	
Patient's Relationship to Subscriber (i.e. self, child, spouse):		
If other than "self", enter information below for subscriber		
Subscriber Name:	DOB:	Gender : Male Female
Mailing Address:		
City, State:	Zip:	

How did you hear about the Achieve Center?

Circle One:	Physician	Friend	Child's School	Internet	Television	Radio
Other:						

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