Growing Healthy Children
Therapy Services, Inc.
3498 Green Valley Rd.
Rescue, CA 95672
Info.ghcot@gmail.com

Patient Name: (Last, First, Mid. Initial): _____ Birth Date _____

Sex: M ☐ F ☐

Patient Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Patient Status: Single ☐ Married ☐ Other ☐ _____
Employed ☐ Full Time Student ☐ Part-Time Student ☐

Pateint's Condition Related to:

Employment? Yes ☐ No ☐
Auto Accident? Yes ☐ No ☐ Place (State) _____
Other Accident? Yes ☐ No ☐

Insured's I.D. Number: _____

Insured's Name (Last, First, Middle Initial): _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Telephone Number: _____

Insured's Policy Group Number: _____

Insured's Date of Birth: _____ Insured's Sex: M ☐ F ☐

Employe's Name or School Name: _____

Insurance Plan Name or Program: _____

Is there another Health Benefit Plan? Yes ☐ No ☐ (if No, form is complete)

Other Insured's Name (Last, First, Middle Initial): _____

Other Insured's Policy Group Number: _____

Other Insured's Date of Birth: _____ Other Insured's Sex: M ☐ F ☐

Employe's Name or School Name: _____

Insurance Plan Name or Program: _____