Milestone Pediatric Therapy Services, Inc
40 Professional Drive Jefferson, GA 30549
Phone: 706-367-1141 Fax: 706-367-1142

Insurance Information

Patient Name: _____Gender: M F DOB: _____

Address: _____

City:_____State:_____Zip: _____

Cell #:_____ Home#:_____ Work #:_____

Email: _____

Diagnosis: (if known) _____

Primary Pediatrician/Physician: _____

Physician's Phone/Address: _____

_____

_____

_____

Primary Insurance

Insured's Name: _____ relationship: _____ DOB: _____

Insurance Company: _____

Insurance ID: _____

Insurance Address: _____

Group /Account #: _____Insurance Phone #: _____

Policy Holder Name:_____ DOB: _____

Policy Holder's Place of Employment: _____

Medicaid: _____

Wellcare: _____ Amerigroup: _____Peachstate: _____

Medicaid ID #: _____

I hereby consent that all information provided on this form is true to the best of my knowledge.

_____ _____ _____

Parent/Guardian (print name) Parent/Guardian signature Date