FAMILY SPEECH & THERAPY SERVICES

Date:

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____
Last First MI

Sex: M / F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Best Daytime Phone: _____

How did you hear about us?: _____

RESPONSIBLE PARTY (PATIENT OR PARENT/LEGAL GUARDIAN)

Name: _____ Sex: M / F
Last First MI

Relationship to Patient: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Best Daytime Phone: _____

Other Parent/
Guardian Name: _____ Sex: M / F
Last First MI

Relationship to Patient: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Best Daytime Phone: _____

PRIMARY CARE PHYSICIAN AND INSURANCE INFORMATION

Primary Care Physician: _____ Phone: _____

Clinic Name: _____

Clinic Address: _____

Primary Insurance: _____

Policy Numbers: _____ _____
ID# Group/Plan #

Policy Holder: _____ Date of Birth: _____
Last Name First Name MI

Relation to Patient: _____ Employer: _____

Secondary Insurance: _____

Policy Numbers: _____ _____
ID# Group/Plan #

Policy Holder: _____ Date of Birth: _____
Last Name First Name MI

Relation to Patient: _____ Employer: _____

Office Use	**ST** Eval Dx: _____ Treatment Dx: _____ Medical Dx: _____	**OT** Eval Dx: _____ Treatment Dx: _____ Medical Dx: _____	