SPEECH LINK

Patient Intake Form

Today's date:

PATIENT INFORMATION			
Patient's last name:	First:	Middle initial:	Sex: M ❒ F ❒
Birth date: / /	Age:	Responsible party:	Relationship to patient:
Street address:		City:	
State & Zip code:	Alternative Contact:	Mom's cell:	Dad's cell:
Preferred contact number:			

INSURANCE INFORMATION		
Please bring your insurance card with you to your first appointment.		
Insured party:	Birth date: / /	Email:
Address (if different):		City:
State & Zip code:	Occupation:	Employer:
Employer address:		Employer phone no.:
Primary Insurance:		Relationship to patient:
Group no:	Policy no:	Patient covered by insurance?: Yes ❒ No ❒

I acknowledge that the above information is true and correct to the best of my knowledge. I authorize treatment for above named patient by the staff of Speech Link. I understand and agree that I am responsible for payment for all services that are provided to me.

Patient/Guardian signature *Date*

Printed name