NEW PATINT INTAKE INFORMATION

If you are seeking speech services for yourself or a family member, please fill out this form. We will verify your insurance benefits and get back to you as soon as possible to schedule a speech evaluation.

Please fill out entire form. All information is necessary to verify your insurance benefits and scheduling your appointment.

Identifying and Family Information:

Patient Name: _____ DOB: _____ Sex: M F

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Email: _____

Insurance

What is your primary Medical Insurance? _____

ID#: _____ Group#_____

Do you have secondary insurance? ___ yes ___ No

If yes, what insurance? _____ ID#_____ Group#_____

Primary Physician's Name: _____ Phone: _____ Fax: _____

When was last Well Check-up/doctor visit? _____

What is your dominant language? _____

Is there a language other than English spoken in the home? __ Yes __ No

If yes, which one? _____

SPEECH-LANGUAGE-HEARING

Please explain your concerns for patient's speech._____

Do you feel patient has a hearing problem? __ Yes __ No

If yes, please describe. _____

Has patient ever had a hearing evaluation/screening? __ Yes __ No

610 Uptown Blvd. Suite 2000-694 • Cedar Hill, TX 75104
Phone: 469-550-9913 • Fax: 469-461-0765