



Patient Registration

Please complete/ print this information carefully and sign at the bottom

Patient's Information:

Patient Name: Date of Birth: Address: SS#: City: State: Zip: Single Married Other Home Phone: Cell Phone: Work Phone: Employer: Employer Address: How did you hear about Specialized Speech Technologies, Inc.?

Parent/Guardian's Information:

Parent/Guardian Name (if patient is a minor): Address (if different from patient): City: State: Zip: Date of Birth: Home Phone: Work Phone: Cell Phone: Relationship to Patient: Email Address:

Treatment Information:

Employment Related: Yes No Auto Accident: Yes No Is there an attorney involved: Yes No Previous Treatment received for same condition: Yes No Unsure If yes, where?

Insurance Information:

The patient's Speech Therapy is covered by medical insurance: Yes No Unsure Insured's Name: Insured's Date of Birth: Insurance Company: Insurance Phone: Policy Number: Group Number: Insurance Address: City: State: Zip: Insurance ID#: Insured's SS#: Insured's Relationship to Patient: Diagnosis: Is there a Secondary Insurance? Yes No If yes, please provide info and notify front desk. Policy Holder Employer: Occupation: Employer Address: City: State: Zip: Work Phone: Email Address:

Emergency Information:

Emergency Contact Name: Phone: Relationship to Parent: Family Physician: Orthodontist: Referring Physician:

Assignment of Benefits/Authorization for Treatment: By signing this registration form, I hereby authorize treatment as deemed necessary by the therapist and authorize Specialized Speech Technologies, Inc. to release medical records upon request.

Print Patient Name/Date

Signature of Patient/ Date

Parent or Responsible Party Print Name (If patient is a minor)/ Date

Parent or Responsible Party Signature (If patient is a minor)/ Date