SLT THERAPY, PLLC

Intake

Patient Information

Name of Patient: _____ Home Phone:_____
Address: _____Work Phone: _____
_____ Cell Phone: _____
Date of Birth: _____ Age: ____ Sex: ____ SS#: _____
Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed
May we leave messages on your voicemail? _____ May we text you? _____
Employer: _____
Employer's Address: _____

Reason for Appointment: _____
_____

Referral

Who referred you to my office?
Name: _____ Address: _____

Family Information

Name of Spouse or Parent: _____ Home Phone:_____
Address: _____Work Phone: _____
_____ Cell Phone: _____
Date of Birth: _____ Age: ____ Sex: ____ SS#: _____
Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed
Employer: _____
Employer's Address: _____

Insured Information

NOTE SLT Therapy, PLLC is not in-network with any insurance company. I do **NOT** bill the insurance company. You will be given a statement that contains all the information needed to file your insurance for reimbursement. **Client is responsible for payment of fees, which will be collected at the time of service.**

Policy Holder's Name: _____ Date of Birth: _____
Insurance Company: _____
ID#: _____ Group#: _____
Employer: _____ SS#: _____
Insurance Company Phone #: _____
Relationship to Patient: _____

Emergency Contact

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency. Please be aware that the person(s) listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

Name and Phone #:

_____

_____