

Patient Information Form

1. Patient

Last name: _____	First: _____	Middle: _____	Birth Date: ___/___/___
Address: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: ___-___-___
Name of Facility: _____	Status:	Current place of residence:	
City: _____	<input type="checkbox"/> Married	<input type="checkbox"/> Home	
State: _____ Zip: _____	<input type="checkbox"/> Single	<input type="checkbox"/> Skilled Nursing Facility	
Home Phone: (____) ____-_____	<input type="checkbox"/> Employed	<input type="checkbox"/> Custodial Facility (assisted living)	
Work Phone: (____) ____-_____	<input type="checkbox"/> Full-Time Student	<input type="checkbox"/> In Hospice Program	
	<input type="checkbox"/> Part-Time Student		

2. Speech Language Pathologist

Name: _____
Phone: (____) ____-_____ Alternate Phone: (____) ____-_____ Fax: (____) ____-_____

3. Treating Physician

Name: _____	NPI Number: _____		
UPIN Number: _____	Medicaid Number: _____		
Address: _____	City: _____	State: _____	Zip: _____
Work Phone: (____) ____-_____	Alternate Phone: (____) ____-_____	Fax: (____) ____-_____	

4. Diagnosis

Primary Diagnosis: _____	Diagnosis Code (ICD-9): _____
Secondary Diagnosis: _____	Diagnosis Code (ICD-9): _____
Third Diagnosis: _____	Diagnosis Code (ICD-9): _____
Fourth Diagnosis: _____	Diagnosis Code (ICD-9): _____

5 Primary Insurance

Type: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPUS / Military Coverage <input type="checkbox"/> Private / Group <input type="checkbox"/> HMO			
Name of Insurance: _____	ID Number: _____		
Billing Address: _____	City: _____	State: _____	Zip: _____
Policy Holder / Insured			
Name: _____	Phone: (____) ____-_____		
Address: _____	City: _____	State: _____	Zip: _____
ID Number: _____	Group Number: _____	Social Security Number: ___-___-___	
Relationship to Client: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other	Date of Birth: ___/___/___		

6. Secondary Insurance

Type: Medicare Medicaid CHAMPUS / Military Coverage Private / Group HMO
Name of Insurance: _____ ID Number: _____
Billing Address: _____ City: _____ State: ____ Zip: _____
Policy Holder / Insured
Name: _____ Phone: (____) ____-____ Fax: (____) ____-____
Address: _____ City: _____ State: ____ Zip: _____
ID Number: _____ Group Number: _____ Social Security Number: __-__-____
Relationship to Client: Spouse Parent Legal Guardian Other Date of Birth: __/__/__

7. Third Insurance

Type: Medicare Medicaid CHAMPUS / Military Coverage Private / Group HMO
Name of Insurance: _____ ID Number: _____
Billing Address: _____ City: _____ State: ____ Zip: _____
Policy Holder / Insured
Name: _____ Phone: (____) ____-____ Fax: (____) ____-____
Address: _____ City: _____ State: ____ Zip: _____
ID Number: _____ Group Number: _____ Social Security Number: __-__-____
Relationship to Client: Spouse Parent Legal Guardian Other Date of Birth: __/__/__

8. Signature of Person(s) Completing this Form

I verify that all information contained in this form is correct and true to the best of my knowledge.

Name (print): _____
Signature: _____ Date: __/__/__