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WELCOME TO OUR OFFICE!

We appreciate your cooperation in filling out this form.

PATIENT INFORMATION:

Patient Name: ______________________________ Date of Birth: ________ Sex: □Female □Male

Home address: ____

City, State: ____ Zip code: ___________

Home tel # _____________________ Cell tel #___________________ Office tel #___________________

Occupation: ___________________________Email: ___________________________

Employer:______________________________Student? □ No □Yes: Name of school: _______________

Marital status: □Single □Married □Widowed □Divorced

INSURANCE INFORMATION

Insurance coverage for speech therapy? □No □Yes: Carrier name:__________________________

Insurance ID# ____________________Group #___________ Relationship to patient: □self □spouse □child

Primary name on insurance policy: ______________________Date of Birth for Primary: _____________

Tel # for Primary: ______________________Employer for Primary: ______________________________

Home Address for Primary: ____

Do you have a secondary health insurance policy as well? ? □No □Yes: Carrier name:_________________

Is this a Worker's Compensation Claim? □No □Yes: Please provide info:____________________________

EMERGENCY CONTACT INFORMATION

Person to notify in case of emergency: _________________________

Relation to patient: □Spouse □Parent □Child □Other_______________

Home tel #__________________________ Work/Cell tel #__________________________

REFERRING PHYSICIAN:

Physician: ____ Tel: _____________________________

Address: ____

OTHERS WHO SHOULD RECEIVE A REPORT (NAME, ADDRESS):

____

____

I understand that I am responsible for any co-payment and deductible amount if Dr. Carroll is a participating provider for my health insurance. If my policy requires a referral, I understand I am responsible for obtaining that referral. I understand that I am responsible for payment of services if Dr. Carroll is an out-of-network provider for my policy and/or my insurance does not cover such services.

Signature: ______________________________