Patient Information Form

1. Patient

Last name:_____ **First**: _____ **Middle**: ___ **Birth Date:** ___/___/____

Address: _____

Name of Facility: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____-_____

Work Phone: (____) _____-_____

Sex: ☐ Male ☐ Female

Social Security Number: ____-___-____

Status:

☐ Married

☐ Single

☐ Employed

☐ Full-Time Student

☐ Part-Time Student

Current place of residence:

☐ Home

☐ Skilled Nursing Facility

☐ Custodial Facility (assisted living)

☐ In Hospice Program

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: ☐ Medicare ☐ Medicaid ☐ CHAMPUS / Military Coverage ☐ Private / Group ☐ 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: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ 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: ___/ ___/ _____