Play to Talk
SPEECH THERAPY

Patient Information

Name: _____ Today's Date: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Preferred contact method:

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Patient's Occupation: _____

Patient's Employer: _____

Parent/Spouse's Name: _____

Parent/Spouse's Employer: _____

Primary Care Physician's Name: _____

Primary Care Physician's Address: _____

City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____

Address (if different from patient address): _____

Phone number (if different from patient phone): _____

How did you hear about this practice?

- ☐ Doctor
- ☐ Friend/Family Member
- ☐ Self
- ☐ Other

Insurance Information

Please give the receptionist a copy of your insurance card

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____

Phone Number: _____

_____

Name of Person Completing This Form

_____

Relationship to Patient