

# Patient Information Form

## 1. Patient

<b>Last name:</b> _____	<b>First:</b> _____	<b>Middle:</b> _____	<b>Birth Date:</b> ___/___/___
<b>Address:</b> _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security Number:</b> ___-___-___	
Name of Facility: _____	<b>Status:</b>	<b>Current place of residence:</b>	
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

<b>Name:</b> _____
Phone: (____) ____-_____      Alternate Phone: (____) ____-_____      Fax: (____) ____-_____

## 3. Treating Physician

<b>Name:</b> _____	<b>NPI Number:</b> _____		
<b>UPIN Number:</b> _____	<b>Medicaid Number:</b> _____		
<b>Address:</b> _____	<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
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: _____
<b>Policy Holder / Insured</b>			
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: \_\_/\_\_/\_\_