Atlantic Speech Therapy
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Patient Information Form

Uncompleted form may delay start date of services

Date:

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/____ Sex: M ☐ F ☐

Parent/Guardian Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Cell: _____ Work: _____

Can we contact you via text message? ☐ Yes ☐ No

Email Address: _____

Best Contact Method (please circle): Email or Phone (best days/times) _____

Does your child currently have an IEP or IFSP in place? ☐ YES ☐ NO

If yes please include the name of the school/agency: _____

INSURANCE INFORMATION (if applicable)

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance: _____ Policy Number: _____

Policy Subscriber: _____ Group Number: _____

Policy Subscriber DOB: _____

Employer Name: _____ Phone: _____

*****Please include a copy of the patient's insurance card. *****
(Front and Back of Card)

Medicaid Number: _____

Address: _____ City: _____ State: _____ Zip: _____

*****Please include a copy of the patient's Medicaid card. *****