



Patient Intake Form

PATIENT INFORMATION		
Child's name: _____		Date of Birth: _____
Address: _____		Phone: _____
City: _____		Zip Code: _____
Father/Guardian name: _____		Age: _____ Parent's occupation: _____
Mother/Guardian name: _____		Age: _____ Parent's occupation: _____
Primary Care Physician _____		Practice Group Name _____
Address _____		Zip _____
Phone number _____		Fax Number _____
Any diagnosis of any kind? _____		
How did you hear of us? _____		
Primary Insurance:		
Co. Name _____		
Insurance ID # _____		Insurance Group # _____
Insurance Phone # _____		
Insured's Name _____		Insured's DOB _____ Insured SS# _____
Insured's Address _____		
Insured's Phone _____		Insured's Employer's Name _____
Each patient is responsible for knowing their insurance coverage benefits.		
Deductible: _____		Has the deductible been met? _____ Co-Pay Per Session for specialists? _____
Visits Allowed: _____		Number of Visits Used this Year _____ Are evaluations covered? _____
Is Preauth for services Required? _____		Is a Prescription for Services Required? _____
Secondary Insurance:		
Co. Name _____		
Insurance Group # _____		Insurance ID # _____ Insurance Phone # _____
Insured's Name _____ Insured's DOB _____ Insured SS# _____		
Insurance co-payments are due at the time of service.		
Certification and Authorization		
<i>I certify that the above information is correct. I hereby authorize Fox Speech Therapy to furnish my insurance carrier any information acquired in the course of the evaluation or treatment necessary to complete the insurance forms. Also, I hereby assign to Fox Speech Therapy all payments for services rendered. In the event that my insurance company does not pay for services rendered, I understand that I am fully responsible for all payments due.</i>		
Responsible Party Signature: _____		Date: _____
<i>(Relationship to patient)</i>		



Contact Information

At times we may need to contact you for appointment reminders or other concerns.

Home Phone _____ Ok to leave message: Yes No

Father's/Guardian

Cell Phone _____ Ok to leave message: Yes No

Work Phone _____ Ok to leave message: Yes No

Email _____ Ok to leave message: Yes No

Mother's/Guardian

Cell Phone _____ Ok to leave message: Yes No

Work Phone _____ Ok to leave message: Yes No

Email _____ Ok to leave message: Yes No

Please select your preferred contact method (one only) for each item listed below:

Appointment Reminders: Home Phone Cell number _____ Email _____

Other Correspondence: Home Phone Cell number _____ Email _____

I authorize the use of the complete items above as an acceptable method of contact

Regarding any information about my child, _____.

Parent Signature

Date