CHILDREN'S SPEECH & FEEDING THERAPY, INC.
PATIENT INFORMATION FORM

Today's Date: _____

PERSONAL

Name (Last, First): _____ Male___Female___

Parent or Guardian Name: _____

Street Address: _____

City, Zip: _____

Phone Number: _____

Email Address: _____

Child's Birth Date: _____SS#: _____

I am paying privately for therapy _____Yes _____No (If no, please fill in insurance info below)

Primary Insurance: _____

Policy #: _____

Insured: _____

Insured DOB: _____ Relationship to Insured: _____

Co-Pay: _____ In a referral on file for this visit?_____

OTHER

Child's Pediatrician's Name: _____

Pediatrician's Number: _____

Your Child's Medical Diagnostic Codes (e.g. prematurity, VSD, Autism, ADHD):

_____

I confirm all above information to be correct.

Parent or Guardian Signature: _____