CLIENT REGISTRATION

Completed By: _____

Date: _____

Client Information

Date of first visit:				**Dx Code#:**
Client: (LAST)		(FIRST)	(MI)	**DOB:**
Address:				
Phone#: (Home)		(Cell)		**SSN#:**
Gender: (circle one) **M** **F** **T**				**Referred By:**
Name of Insured:				**DOB:**
Primary Ins. Co. :				**SSN#:**
Member ID #:				**Group #:**
Address:				
Employer:				
Telephone:				

CLIENT REGISTRATION

Completed By: _____

Date: _____

Spouse, Mother, Father Info: (LAST)	(FIRST)	(MI)	**DOB:**	
Address:				
Phone#: (Home)	(Cell)	**SSN#:**		
Email:				
Other Family Members: (LAST)	(FIRST)	(MI)	**DOB:**	
(LAST)	(FIRST)	(MI)	**DOB:**	
(LAST)	(FIRST)	(MI)	**DOB:**	
Guarantor (Responsible Party for Payment) : (LAST)	(FIRST)	(MI)	**DOB:**	
Address:	**Relationship to Client:**			
Phone#: (Home)	(Cell)	**SSN#:**		
Referral Information: How did you hear about us?				
Primary Care Physician: **:** (LAST)	(FIRST)	(MI)	(Address)	

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Do you have a physician referral?
Diagnosis:
Medical or Other Conditions:
Describe your communication problem or reason for visit:
What would you like your outcome of your appointment to be?
Additional Info:

I request payment of authorized health insurance or medical benefits be made to Center4Speech for any services furnished by that provider. I hereby authorize release of any medical information necessary to process this claim to HCFA or my Health Insurance Carrier and its agents to determine these benefits or the benefits payable for related services. I understand that I am responsible for all charges not covered by my insurance provider.

Signature_____ Date_____