ASSOCIATED SPEECH & LANGUAGE SPECIALISTS

PATIENT INTAKE

Date: _____ Patients Name: _____

DOB: _____ Age: _____ Sex: _____ Location St. Paul

Parent's Name: _____

Address: _____

_____

Email Address: _____

Phone Numbers:

Home: _____ Cell: _____ Work: _____

Do we have permission to email or leave you a voicemail regarding your appointment?

Primary
Insurance: _____ ID: _____ Group #: _____

Secondary
Insurance: _____ ID: _____ Group #: _____

Policy Holder (Name) Physician: _____

Place of Employment: _____ Clinic: _____

Referral Source – How did you hear about us: _____

Please describe concerns: _____

_____

Has the patient been evaluated for speech & language concerns?

If so, when: _____ where:

Has the patient ever received speech & language concerns?

If so, when: _____ where:

Has the patient ever been eval'd by other professionals: Psychologists, Neuropsychologists, OT?

If so, when: _____ where:

Has the patient's hearing recently been checked?

If so, when: _____ where:

Please obtain any eval reports and/or current IEP's prior to the eval appt. Check insurance regarding speech evals & speech therapy coverage. May need to contact the PCP for a doctor's referral/order

Revised 8/28/12, 8/8/13, 4/9/14, 12/4/19,