Buckhead/Midtown Office
Brookwood Exchange Building
1708 Peachtree Street NW
Suite 525
Atlanta, GA 30309

Pediatric Speech Therapy
Teaching Children. Coaching Parents.

Gainesville Office
Rubicon Lakefront Office Building
25665 Thompson Bridge Road
Suite 207
Gainesville, GA 30501

Alpharetta Office
Pediatric Speech Therapy
4080 McGinnis Ferry Road
Building 300, Suite 302
Alpharetta, GA 30005
770-410-7719 OFC 770-410-9510 FAX

Patient Intake Form

For Patients setting up New Patient data for the first time, please complete all data. For existing Patients, simply complete fields in which you would like to make changes to the information on file . When completed, fax the completed Form to Pediatric Speech Therapy @ (770) 410-9510 or bring with you to first session.

Patient

Patient Last Name* | **First Name*** | **MI*** | **Name of Referring Physician**

Patient Address* | **Sex*** Male ☐ Female ☐ | **Patient DOB***

City* | **State*** | **Patient SSN***

Zip Code* | **Patient Marital Status*** Single ☐ Married ☐ Other ☐

Phone Number* | **Patient Employment Status*** Employed ☐ Full time Student ☐ Part time Student ☐ Retired ☐ Other ☐

Fax Number

Email Address

Patient Weight | **Height**

Patient Diagnosis Codes* (1. 2. 3. 4.) | **Patient Procedure Codes** (1. 2. 3. 4.)

Patient Speech Issues:

Insurance Information

Primary Insurance

Primary Insured's Name* | **SSN*** | **Insurance Card Effective Date**

Primary Insured's Address* | **Phone Number*** | **Sex*** Male ☐ Female ☐ | **Insurance Card Termination Date**

City* | **State*** | **Insured's DOB***

Zip Code* | **Primary Insurance Type*** Group ☐ Individual ☐ Medicaid ☐ Medicare ☐ HMO ☐ PPO ☐ Other ☐

Primary Insured's ID#*

Policy Group or FECA Number*

Employer's Name or School Name*

Primary Insurance Program Name*

Primary Carrier*	
Address1*	
Address2*	
City*	
State*	
Zip*	
Telephone*	
Fax Number	
Email Address*	
Payer Electronic ID#*	
This Carrier is Primary Source of Payment	Yes ☐

Secondary insurance

Secondary Insured's Name*

SSN*

Insurance Card Effective Date

Secondary Insured's Address*

Phone Number*

Sex*

Male ☐

Female ☐

Insurance Card Termination Date

City*

State*

Insured's DOB*

Secondary Insurance Type*

Group ☐ Individual ☐

Medicaid ☐ Medicare ☐

HMO ☐ PPO ☐ Other ☐

Zip Code*

Secondary Insured's ID#*

Secondary Carrier*

Address1*

Address2*

City*

State*

Zip*

Telephone*

Fax Number

Email Address*

Payer Electronic ID#*

ID Ext

Office No.

Policy Group or FECA Number*

Employer's Name or School Name*

Secondary Insurance Program Name*

This Carrier is Secondary Source of Payment

Yes ☐

Other insurance

Other Insured's Name*

SSN*

Insurance Card Effective Date

Other Insured's Address*

Phone Number*

Sex*

Male ☐

Female ☐

Insurance Card Termination Date

City*

State*

Insured's DOB*

Other Insurance Type*

Group ☐ Individual ☐

Medicaid ☐ Medicare ☐

HMO ☐ PPO ☐ Other ☐

Zip Code*

Other Insured's ID#*

Other Carrier*

Address1*

Address2*

City*

State*

Zip*

Telephone*

Fax Number

Email Address*

Payer Electronic ID#*

Policy Group or FECA Number*

Employer's Name or School Name*

Other Insurance Program Name*

This Carrier is Final Source of Payment

Yes ☐

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Provider. I understand that I am financially responsible for any balance. I also authorize the Provider to release any information required to process my claims. I will notify Provider as soon as any of the above information changes.

X _____

Patient/Guardian Signature Date