Talk Sense
Occupational and Speech Therapy

Patient's Name: _____ **SS #:** _____

First Name MI Last Name

Date of Birth: _____ ☐Male ☐ Female ☑Single ☐Married ☐Widowed ☐ Divorced ☐ Separated

Street Address: _____

City/State/Zip Code: _____ **Home Phone:** _____

Cell Phone: _____ **Fax**: _____

Patient's Employer: _____ **Work Phone:** _____

Spouse's Name: _____ **SS #:** _____

Spouse's Employer: _____ **Spouse's Work Phone #:**_____

Credit: (Circle) MC Visa #_____ Exp ___/___/___ Name on card: _____

Responsible Party: _____ **Relationship:** ☐Self ☐Spouse ☐Parent ☐Other:_____

If patient is a Minor, are parents ☐Married ☐Divorced Custodial Parent: _____

Custodial Parent's Home Phone: _____ **Work Phone:** _____

Custodial Parent's SS #:_____ **Date of Birth:** _____

In case of emergency, contact (not living with you):_____

Phone Number: _____ **Relationship to Patient:** _____

Is this work-related? ☐Yes ☐No **If yes, date of injury?** _____ **Claim #:** _____

How did this injury happen? _____

_____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID AND COMPLETE BELOW REQUESTED INFORMATION

Insurance Company # 1:_____ **Phone Number:** _____

Primary Insured's Name: _____ **Date of Birth:** _____

Policy #:_____ **Group #:**_____ **Relationship:** _____

Insurance Company # 2:_____ **Phone Number:** _____

Primary Insured's Name: _____ **Date of Birth:** _____

Policy #:_____ **Group #:**_____ **Relationship:** _____

If you do not have insurance, have you applied for Medicaid? ☐Yes ☐No If yes, what is the name and phone number of the social worker with whom you are working? _____
