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Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

Please take a moment to fill out the following information. Thank you.

PATIENT REGISTRATION/INTAKE FORM

Today's date_____

IDENTIFYING DATA:
Patient Last Name, First name_____
Social Security No.:_____
Social Security No. of person responsible for payment_____
Parents Names:_____
Address:_____
Zip:_____
Home Phone:_____Work phone_____
Cell Phone:_____
Patient's Date of Birth:_____
Referring Physician's Name:_____
Physician's Phone # and Address:_____
Referred by:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____
ID#:_____
Plan:_____
Group:_____
Subscriber's Name:_____
Relationship to Patient:_____
Subscriber's Employer:_____

Secondary Insurance Company:_____
ID#:_____
Plan:_____
Group:_____
Subscriber's Name:_____
Relationship to Patient:_____
Subscriber's Employer:_____

Please Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. Please note if a claim is submitted to an insurance company on your behalf, the health information on this form will be shared with your carrier.

Signature_____ Date:_____