



The Scholl Center for Communication Disorders

Today's Date: _____

Preferred to be called: _____

| | | |
|----------------------------|--------------------------|-----------------------|
| Patient Information | Social Security #: _____ | Home Phone: _____ |
| | Last Name: _____ | Work Phone: _____ |
| | First Name, MI: _____ | Cell Phone: _____ |
| | Date of Birth: _____ | Sex: _____ |
| | Street Address: _____ | Employer: _____ |
| | Apt. # / P.O. Box: _____ | Email Address: _____ |
| | City: _____ State: _____ | Marital Status: _____ |
| | Zip Code: _____ | |
| | Referring Dr.: _____ | |

| | | |
|--------------------------|--|--------------------------|
| Responsible Party | Relationship to Patient: _____ | Home Phone: _____ |
| | Last Name: _____ | Work Phone: _____ |
| | First Name, Initial _____ Initial: _____ | Cell Phone: _____ |
| | Street Address: _____ | Sex: _____ |
| | Apt. # / P.O. Box: _____ | Date of Birth: _____ |
| | City: _____ State: _____ | Social Security #: _____ |
| | Zip Code: _____ | Employer: _____ |
| | | Email: _____ |

| | | |
|--------------------------|----------------------------------|--------------------------|
| Responsible Party | Relationship to Patient: _____ | Home Phone: _____ |
| | Last Name: _____ | Work Phone: _____ |
| | First Name: _____ Initial: _____ | Cell Phone: _____ |
| | Street Address: _____ | Sex: _____ |
| | Apt. # / P.O. Box: _____ | Date of Birth: _____ |
| | City: _____ State: _____ | Social Security #: _____ |
| | Zip Code: _____ | Employer: _____ |
| | | Email: _____ |

| | | |
|--------------------------|--|-------------------------------|
| Primary Insurance | Insurance Company: _____ | Employer: _____ |
| | Insured's Last Name: _____ | Policy or I.D.#: _____ |
| | Insured's First Name: _____ Initial: _____ | Group Name or #: _____ |
| | Sex: _____ | Policy Phone #: _____ |
| | Date of Birth: _____ | Patient's Relationship: _____ |
| | Social Security #: _____ | |
| | | |

| | | |
|--------------------------|--|-------------------------------|
| Primary Insurance | Insurance Company: _____ | Employer: _____ |
| | Insured's Last Name: _____ | Policy or I.D.#: _____ |
| | Insured's First Name: _____ Initial: _____ | Group Name or #: _____ |
| | Sex: _____ | Policy Phone #: _____ |
| | Date of Birth: _____ | Patient's Relationship: _____ |
| | Social Security #: _____ | |
| | | |

Emergency Contact: _____ Phone #: _____ Alt. Phone #: _____

The above information is true to the best of my knowledge.

Patient/Guardian signature: _____ Relationship: _____ Date: _____