|  |  |
| --- | --- |
| **Today's date:** | - |
| **Client information:** | - |
|  First name | - |
|  Middle initial | - |
|  Last name | - |
|  Address | - |
|  City | - |
|  State | - |
|  Zip code | - |
|  Email address | - |
|  Home phone | - |
|  Work phone | - |
|  Mobile phone | - |
|  FAX | - |
|  Birth date | - |
|  Gender (M or F) | - |
|  Marital Status | - |
| **Parent/Guardian 1 information:** |  |
|  First name | - |
|  Middle initial | - |
|  Last name | - |
|  Address | - |
|  City | - |
|  State | - |
|  Zip code | - |
|  Email address | - |
|  Home phone | - |
|  Work phone | - |
|  Mobile phone | - |
|  FAX | - |
| **Parent/Guardian 2 information:** |  |
|  First name | - |
|  Middle initial | - |
|  Last name | - |
|  Address | - |
|  City | - |
|  State | - |
|  Zip code | - |
|  Email address | - |
|  Home phone | - |
|  Work phone | - |
|  Mobile phone | - |
|  FAX | - |

|  |  |
| --- | --- |
| **Insurance information:** |  |
|  Insurance company | - |
|  ID number | - |
|  Group number | - |
|  Insurance company address for claims | - |
|  City | - |
|  State | - |
|  Zip code | - |
|  Insurance company claims phone number | - |
|  Number of sessions allowed per year | - |
|  Copayment per session | - |
| **Person responsible for payment:** |  |
|  First Name | - |
|  Last Name | - |
|  Address | - |
|  City | - |
|  State | - |
|  Zip code | - |
|  Phone | - |
|  Employer | - |
|  Birth date | - |
|  Gender (M or F) | - |
|  Client's relationship (child, self, spouse) | - |

|  |  |
| --- | --- |
| **Health information:** |  |
|  Date of last hearing exam | - |
|  Hearing exam results | - |
|  Referred by | - |
|  Physician's name | - |
|  Physician's phone number | - |
|  Dentist's name | - |
|  Dentist's phone number | - |
|  Orthodontist's name | - |
|  Orthodontist's phone number | - |
|  What are your speech-language concerns? | - |
| Please list in detail any medical conditions that may be related to this concern:(ex: ear infections, surgery, etc.) | - |
| Has the client ever received any speech-language, physical, occupational or other therapies? Please list service provider names, phone numbers, and dates of service. | - |
| Other information/comments? | - |
| **How did you hear about Jackie Myland & Associates?** |  |
| Insurance company provider directory | - |
| Yellow pages | - |
| Google search | - |
| Referred by friend | - |
| Referred by physician | - |
| Referred by dentist/orthodontist | - |
| Referred by school | - |