|  |  |
| --- | --- |
| **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 | - |