

Speech Pathology Outpatient Registration Form
Please complete this entire form then forward it to the Admitting Department

Today's Date: _____ Name of Person Completing Form: _____

Patient's Information: Name: _____ Date of Birth: _____ SS# _____

Address: _____

Phone Number: _____

Physician's Information: Name: _____ Phone# _____ Fax#: _____

Address: _____

Insurance Information: **Name of Primary Insurance Company:** _____ (If Medicaid, verify if MediPass)

Policy #: _____ (if Medicare indicate if A &/or B & name of policy holder if other than pt.)

Group#: _____ Contact Phone#: _____

Name of Secondary Insurance Company: _____

Policy #: _____ (if Medicare indicate if A &/or B & name of policy holder if other than pt.)

Group#: _____ Contact Phone#: _____

Authorization Information: Authorization/Referral # _____

#Visits: _____ Expiration Date: _____

Prescription Information: Diagnosis: _____

Date on Prescription (must be within last 14 days): _____ Date of last appt. with referring MD: _____

Requested Tx: _____

Frequency of Treatments : _____

Appointment Information: Date & Time of First Appointment: _____

Comments / Other: _____

AFTER REGISTRATION, PLEASE SEND THIS PATIENT TO:
[] **RADIOLOGY DEPARTMENT**
[] **SPEECH THERAPY DEPT. - 2ND FL NEXT TO P.T.**