CLIENT INFORMATION FORM

Client Name: _____ DOB:_____
Exactly as it appears on the insurance card

Gender: male female Race: _____

Address: _____

_____

Telephone: Home: _____ Work: _____

Parent/Guardian: _____

Emergency Contact Person: _____

Emergency Contact Person Phone #: _____

Client Social Security Number: _____-_____-_____

Insurance Name: _____ Insurance ID#: _____
(BC/BS, Medicaid, Interactive Medical Systems, Health Choice, etc.) (Medicaid Recipient ID #)

Physician: _____
Doctor listed on Medicaid or Insurance Card

Where do you want therapy to be held: Home Daycare School

Location: _____ Location phone #: _____

SLP Assigned to the Patient: _____

SLP-A Assigned to the Patient: _____

Directions to Home:_____
_____

All information will be placed in client's confidential folder and will not be shared with any person or agency without your permission or consent to release information. Thank you-SSI

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