



PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

Child's First Name: _____ Middle Initial: _____ Last Name: _____

Child's Birthdate: _____ Pediatrician: _____

Parent/Guardian's Names: _____

Mailing Address: _____ City: _____ Zip: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Emergency Contact: _____ Phone: _____

Email address: _____

CLINICAL INFORMATION

Please state briefly your area/s of concern for your child (use back of page if necessary)

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone #: _____

Name of Policy Holder: _____

Policy Group #: _____ Policy ID #: _____

Policy Holder's DOB: _____ Relationship to Patient: _____

I do not have secondary insurance

I do have secondary insurance with: _____

ASSIGNMENT & RELEASE

I, the undersigned certify that my child has insurance coverage with the insurance company listed above, and assign directly to Sara S. Kemp, SLP, INC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Parent's Signature

Date

This form is the property of:
Sara S. Kemp, SLP, INC.