PATIENT DEMOGRAPHICS

Patient Name: First Middle Last				DOB:
Home Address:		City:	State:	Zip:
Occupation:	Social Security #:	Marital Status:	Gender:	Home Phone:
Employer:		Address:		Work Phone:
Spouse (or Parent) Name:		Spouse (or Parent) Address:		Patient (or Parent) Cell Phone:
Spouse (or Parent) Employer:		Spouse (or Parent) Home Phone:		Spouse (or Parent) Work Phone:
Nearest Relative/Friend:	Relationship:		Home Phone:	Work Phone:
Referred by:		Address:		Telephone:

Primary Insurance

Insurance Company Name:		ID or Policy Number:	Group/Code:
Insurance Company Address:		Subscriber's Social Security #:	Date Effective:
Subscriber's Name:	Gender:	Home Phone:	Relationship to Patient:
Subscriber's Address:		Work Phone:	Subscriber's Date of Birth:

Secondary Insurance

Insurance Company Name:		ID or Policy Number:	Group/Code:
Insurance Company Address:		Subscriber's Social Security #:	Date Effective:
Subscriber's Name:	Gender:	Home Phone:	Relationship to Patient:
Subscriber's Address:		Work Phone:	Subscriber's Date of Birth:

I hereby authorize Washington Speech-Language Pathology Group PLLC and its billing agent, Physician Associates, to apply for benefits on my behalf for covered services rendered. I request payment directly to the above named provider.

I certify the information I have reported with regard to my insurance coverage is correct and authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, the insurance company named above and/or my primary care physician. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or me at any time in writing.

Date ________________ Signature of Subscriber _____________________________________

Print Name of Subscriber____________________________________