



**Center for Speech, Language and Learning, Inc.**

**Registration Information- Adult**

Name:	Date:
Date of Birth:	Age:
Address:	
City:	State/Zip:
Email address:	Home Phone:
Place of Employment:	Work Phone:
Education:	Cell Phone:
Spouse:	DOB:
Address:	
City:	State/Zip:
Email address:	Home Phone:
Place of Employment:	Work Phone:
Education:	Cell Phone:
Parent: (if dependent)	DOB:
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
Place of Employment:	Work Phone:
<b>INSURANCE INFORMATION:</b>	
<b>Primary Insurance Company:</b>	Group Number:
Policy Holder:	ID Number:
Employer	
<b>Secondary Insurance Company:</b>	Group Number:
Policy Holder:	ID Number:

## REGISTRATION INFORMATION CONTINUED

**Primary Care Physician:**

Address:

Phone Number:

Fax Number:

\*please list other physicians involved in your care as applicable to your current concerns:

List names and ages of family members in household:

What are your concerns at this time?

How long has this been of concern to you?

Have you had evaluations done by other professionals?  Yes  No  
If "yes", please list when and by whom:

Would you provide copies of those reports, if requested?  Yes  No

Have you ever received therapy for your current concerns, either as a child or adult?

Would you like information on community resources?  Yes  No

Do you currently work with a social worker or case manager, and if so, would you provide their name(s) and permission to contact them?  Yes  No

Name and contact information: \_\_\_\_\_

Please list other individuals who are involved in taking care of the patient, such as spouse or caregiver, with whom you authorize **Center for Speech, Language and Learning, Inc.** to discuss the patient's treatment or release child into the care of in case of emergency.

## REGISTRATION INFORMATION CONTINUED

NAME: \_\_\_\_\_

RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: (\_\_\_\_\_) \_\_\_\_\_ EVE PHONE: (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ EMERGENCY CONTACT: \_\_\_\_ YES \_\_\_\_ NO

### HOW DID YOU HEAR ABOUT US?

\_\_\_\_ Phonebook

\_\_\_\_ Website

\_\_\_\_ Friend \_\_\_\_\_

\_\_\_\_ Doctor \_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_