Professional Voice Care Center

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_________	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Person financially responsible for this account	[ ] Self [ ] Spouse [ ] Parent	Responsible Party's Birthdate ____/____/_______	Responsible Party's Social Security #
Responsible Party Drivers License State: Number		Occupation	How Long at current Employer?
Name of employer Address			Business phone
Name of Spouse/Parent	Birth date	Social Security #	
Reason for Visit:	Referred by: (include address and phone)		
Primary Care Physician	Address and Phone #		
Person to contact in case of emergency:		Relationship to patient	Phone

Primary insurance company Address		Phone #	Effective Date
Subscriber Name	Subscriber birth date	Policy ID #	Group #
Secondary insurance company Address		Phone #	Effective Date
Subscriber Name	Subscriber birth date	Policy ID #	Group #

Are you currently going for Physical Therapy? Yes / No If yes, how many visits have you used this year? ___________

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Karen Sussman, M.A., CCC for any services furnished me by the Speech-Language Pathologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

____ ______________________________
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Karen Sussman, M.A., CCC for any services furnished me by the Speech-Language Pathologist. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ ______________________________
Patient, Parent or Guardian Signature (if child is under 18 years old) Date