



Lisa M. Phillips, M.S. CCC/SLP
1048 Lancaster Street, Leominster, MA 01453
Telephone (401) 465-3004 • www.phillipsspeechtherapy.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION	DATE:
PATIENT NAME: _____	
DATE OF BIRTH: _____ - _____ - _____ SEX: M F	
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	

PARENT/LEGAL GUARDIAN	
NAME: _____	
RELATION TO PATIENT: _____	
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
EMAIL ADDRESS: _____ DO YOU CHECK THIS REGULARLY? _____	
DAY PHONE: (____) _____ EVE PHONE: (____) _____ CELL PHONE: (____) _____	
NAME: _____	
RELATION TO PATIENT: _____	
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
EMAIL ADDRESS: _____ DO YOU CHECK THIS REGULARLY? _____	

INSURANCE INFORMATION	
PRIMARY CARE PHYSICIAN NAME: _____	
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
PHONE: (____) _____	
POLICY SUBSCRIBER: _____ TYPE OF POLICY: _____	
PATIENT ID #: _____	



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CHILD'S NAME:

DATE:

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive Phillips' Speech and Language Services Notice of Privacy Practices:

PATIENT NAME (printed):

Signature: Date:

Parent/Legal Guardian or Self

AUTHORIZED PERSON'S SIGNATURE: I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: Date:

Records Release:

PATIENTS' OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize the release of any necessary information to process insurance claims, including medical and billing information to/from Phillips Speech Therapy from/to the referring physician.

Signature: Date:

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Lisa Phillips to use and/or disclose certain protected health information (PHI) about me to: Insurance Co., Attorneys, Family Member, Spouse, Dentist, Mental Health Professionals, Doctors, Teachers, Other Speech-Language Pathologists, Audiologists, Other (Please Specify)

This authorization permits Lisa Phillips to use and/or disclose the following individually identifiable information about me (specifically describe the information to be used or disclosed, such as date of services, type of services, level of detail to be released, origin of information, etc.; may write in "SLP discretion" if you so desire):

The information will be used or disclosed for the following purpose: treatment, consultation, evaluation, counseling, other (please specify)

This authorization will expire on, or when (furnish date or defined event) Automatically valid for 6 years unless otherwise specified or dated.



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Client Name:

Date:

MEDICAL HISTORY:

YES NO

- Was your child's activity level average as a baby and toddler?
Does your child have allergies or are allergies suspected?
Was development of teeth normal?
Does your child have difficulty with attention?

**Please comment on any of the above areas that were unusual:

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?

Has your child had hearing testing or tympanometric testing? When and where? Does your child have tubes in his/her ears? Do you have any concerns about his/her hearing?

Does your child play well with other children? Do you have any concerns about your child's play?

Does your child have any academic difficulties?

When did your child first exhibit the following speech/language skills?

Table with 3 columns: Milestone, Age, Comments. Rows include Babbling, Imitating Words, Using first word meaningfully, and Putting words together.



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Did your child's speech/language development seem to develop normally and then stop or regress?

Does (s)he understand what is said to her?

Does (s)he follow spoken directions?

Does (s)he talk in (check one) single words ____; phrases ____; complete but grammatically incorrect sentences ____; complete grammatically correct sentences ____.

Does (s)he retell stories or experiences that can be understood? _____

Does (s)he often hesitate and/or repeat sounds and words? _____

Is his/her speech (check one) too fast ____, too slow ____, average ____ ?

Is his/her voice (check) too soft ____, too loud ____, average loudness ____, hoarse ____, nasal ____, denasal (stuffed as during a cold) ____, other ____ ?

ENVIRONMENTAL HISTORY:

Names of Siblings

Birth Dates

Others in the Home _____

Have any other family members or relatives had the following difficulties?

Table with 3 columns: Difficulty, Yes/No, Relationship to Child. Rows include Speech or Language Problem and Hearing Problem.



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<i>Difficulty</i>	<i>Yes/No</i>	<i>Relationship to Child</i>
Learning Disability	_____	_____
Reading Problem	_____	_____
Emotional Problems	_____	_____
Other	_____	_____

PRIOR EVALUATIONS/THERAPY:

Has your child been seen by any other specialists? Yes ____ No ____

Please list any specialists your child has seen for medical, developmental, or educational concerns. Please list current therapists, if any.

Please add any additional comments or information that we may need to know in order to better serve your child. Thank you.

****Please return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating your child.**