

# **INTAKE FORM**

## **Eugene Hearing and Speech Center**

In order to give you the best service and to keep the time spent in the evaluation at a minimum, we ask you to provide us with the information below. Please return this questionnaire to us as soon as possible, or bring the completed form with you to the evaluation. Also, please provide any additional copies of tests administered elsewhere or other information that you feel might be of help. Thank you.

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Emergency: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Patient's E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Other Physicians and/or Agencies Now Seeing Patient: \_\_\_\_\_

Have You Been To The Eugene Hearing and Speech Center for Speech, Language, or Hearing Services? \_\_\_\_\_

What type of Service? \_\_\_\_\_ When? \_\_\_\_\_

Primary Language Spoken in the Home: \_\_\_\_\_ Other Languages Spoken: \_\_\_\_\_

Nationality: Asian \_\_\_\_\_ Black \_\_\_\_\_ White \_\_\_\_\_ Native American \_\_\_\_\_ Hispanic \_\_\_\_\_ Other \_\_\_\_\_

### **Complete If Patient Is Over 21**

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### **Complete If Patient Is Under 21**

Father's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Parents are: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Remarried \_\_\_\_\_ Never Married \_\_\_\_\_

Child is: Adopted \_\_\_\_\_ Foster \_\_\_\_\_

Child lives with: Father \_\_\_\_\_ Mother \_\_\_\_\_ Both \_\_\_\_\_ Other: \_\_\_\_\_

## **INSURANCE / BILLING INFORMATION**

(Must be completed)

You are asked to make a payment on the day of the appointment. In the case of therapy, payment is to be made by the last day of the month in which the therapy is provided. Payments may be made by cash, Visa, Master Card or Discover Card. Any other payment arrangements must be made with the Director of Finance prior to your appointment or scheduled therapy.

### **Primary Insurance Coverage:**

Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

### **Secondary Insurance Coverage:**

Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

### **Other Insurance:**

Medicare Number: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Are you on Welfare/Medicaid? Yes / No ID #: \_\_\_\_\_

All speech/language or hearing services funded through your current Medicaid Card must be prior authorized. Please present your Medicaid Card to the secretary before your appointment, a current card must be on file at all times.

**I understand I am responsible for payment of this account. My insurance (if any) will be billed for appropriate services. I am also responsible for negotiating settlement on disputed claims.**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **RELEASE OF INFORMATION**

(Must be completed)

I authorize and request the Eugene Speech and Hearing Center to obtain, release, and/or exchange pertinent medical, social and educational information with the **physicians, schools, and/or social agencies, etc.**, listed below:

<b>NAME:</b>	<b>COMPLETE ADDRESS:</b>

It is understood that this information will be kept strictly confidential. The Eugene Hearing and Speech Center may need to exchange information regarding this client with private insurance and/or other third party payors. This signed release allows us to do so.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(or Signature of Parent/Legal Guardian)