

Advanced Speech & Language Associates, LLC

Pediatric Therapy Intake Form

Child's Name:	DOB:	Sex:
Parent/Caregiver Name(s):	Relationship to child:	Address:
Home Phone Number:	Cell phone number:	Emergency Contact Name: Phone Number:
Email Address:	Referred by:	Primary Care Physician: Phone Number:
Medications:	Specific Diet:	Allergies:
Diagnosis:	School/Grade:	Other important information:

Insurance Information

Insurance Subscriber's Name:	Relationship to Child:	Insurance Subscriber's DOB:	Insurance Subscriber's Address:
Name of Insurance Company:	Insurance Policy Number:	Insurance Group Number:	Insurance Company's Phone Number:
Insurance Subscriber's Social Security Number:	Secondary Insurance Company (e.g., Medicaid, TriCare, Nevada Check-up) Name:	Secondary Insurance Policy Number	Has insurance been billed for speech therapy during this calendar year? YES/NO Where: _____ and How many visits: _____ What: Speech, OT and/or PT

I verify that all personal and insurance information is accurate. I verify that I received a copy of ASLA's HIPAA policy.

(signature) _____ Date: _____