South Shore Speech, Language and Swallowing Disorders, PLLC
400 Montauk Highway, Suite 152, Babylon, NY 11702
Phone: 631-669-7098 Fax: 631-669-3736

PATIENT REGISTRATION FORM

PATIENT INFORMATION SECTION:

PATIENTS NAME: FIRST_____MIDDLE_____LAST_____

STREET_____CITY_____STATE_____ZIP CODE_____

PATIENT'S AGE_____DATE OF BIRTH_____SS#_____

MALE/FEMALE_____MARITAL STATUS_____PHONE #_____EMAIL_____

EMPLOYER_____WORK #_____

PRIMARY INSURANCE INFORMATION:

INSURED'S NAME: FIRST_____MIDDLE_____LAST_____

INSURED'S SOCIAL SECURITY #_____DATE OF BIRTH_____

MALE/FEMALE_____RELATIONSHIP TO PATIENT_____PHONE #_____

NAME OF PRIMARY INSURANCE CARRIER: _____

ADDRESS_____PHONE # OF CARRIER_____

CO-PAY AMOUNT FOR DR. VISISTS_____DEDUCTABLE AMOUNT_____

IDENTIFICATION #_____GROUP #_____

EFFECTIVE DATE OF INSURANCE_____

SECONDARY INSURANCE INFORMATION:

POLICY HOLDER NAME_____DOB_____ RELATIONSHIP TO PATIENT_____

SOCIAL SECURITY #_____PHONE #_____WORK #_____

NAME OF SECONDARY INSURANCE POLICY: _____

CO-PAY AMOUNT FOR DR. VISITS_____DEDUCTABLE AMOUNT_____

IDENTIFICATION #_____GROUP #_____

EFFECTIVE DATE OF INSURANCE_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE SENT DIRECTLY TO THE PROVIDER

PATIENT'S/AUTHORIZED SIGNATURE _____

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY/OR DEPENDENT'S MEDICAL CLAIMS - PATIENT'S/AUTHORIZED SIGNATURE _____

I AGREE ANY AMOUNT IN WHICH MY INSURANCE COMPANY STATES IS OWED BY ME, WILL BE MY RESPONSIBILITY. I FURTHER AGREE TO REMIT ANY DIFFERENCE WITHIN TEN (10) DAYS OF NOTIFICATION THAT ANY AMOUNT EXITS.

I AM AWARE THAT THERE IS A FEE OF $25.00 FOR EACH MISSED THERAPY SESSION WITHOUT 24 HR. NOTIFICATION.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

OTHER MEDICAL/RELATED PROFESSIONALS WHOM YOU WOULD LIKE A COPY OF THE REPORT TO GO TO:

_____

_____

_____