Wake Pediatric Speech Therapy

CARY office:
1157 Executive Circle
Suite B1, Cary, NC 27511

Contact Information:
(P) 919-593-8104
(F) 919-882-8110

CLAYTON office:
9933 U.S. 70 Bus. Hwy W.
Clayton, NC 27520

Patient Information

All information obtained on this form will be confidential. Patient information is needed for processing insurance claims and implementing the most appropriate therapy services.

PATIENT INFORMATION:

Name: _____ Age: ____ Sex: ____

Date of Birth: _____ Phone: (h) _____

Address: _____
(street number) (city) (zip)

Name of school or preschool: _____ Grade: _____

Referred by: _____

Name of Pediatrician & Practice: _____

_____

Please describe your specific concerns: _____
_____

Please list family members living in the home: _____

_____

Please list any other languages spoken in the home: _____

Was the patient born premature? _____ If so, at how many weeks? _____

Describe a typical day for your child (ex: at home, attends daycare, school, etc.): _____

_____

If your child is not yet talking, how does he/she communicate his/her wants and needs (ex: pointing, leading you by the hand, etc): _____

_____

PARENT INFORMATION:

Parent Name(s): _____

Date(s) of Birth: _____

Phone: (h): _____ (c): _____ (w): _____

Address: (if different)_____

Email Address: _____

Occupation: _____

Employer: _____

In case of emergency contact:

Name: _____ Phone: _____

MEDICAL AND DEVELOPMENTAL HISTORY:

List any hospitalizations, surgeries, or serious illnesses along with the date of occurrence:

_____

_____

Does your child have a history of ear infections? If so, please explain: _____

_____

Please list the approximate age of your child when he/she achieved the following milestones:

_____ babbled _____ said first words _____ combined words

_____ crawled _____ walked _____ stood

_____ sat up _____ fed self _____ toileted

Does your child have any feeding difficulties? _____

List any medications your child is currently taking: _____

_____

List any previous screenings or evaluations your child has received and when: _____

_____

Has your child received any previous therapies (if so, please explain): _____

_____

List any diagnosis that has been given to your child: _____

_____

Does your child currently have an IEP/IFSP (if so, please bring to initial visit): _____

Does your child appear to be aware of or frustrated by any speech or language difficulties? _____

_____

INSURANCE INFORMATION:

Name of Primary Insurance Company: _____

Address: _____ Phone: _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Name of Secondary Insurance Company: _____

Address: _____ Phone: _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Please have your insurance card at your initial visit so that we may make a copy.

If you would like for us to file your claims, please read the authorization statement and sign below:

AUTHORIZATION to release information / payment of insurance benefits: I authorize Wake Pediatric Speech Therapy to provide my insurance company any information obtained through speech therapy evaluations and/or treatment as needed for insurance purposes. I recognize that in the event that my insurance company does not pay for services rendered, I am fully responsible for all payments due.

Signed: _____ Date: _____