Phillips
SPEECH AND LANGUAGE THERAPY

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

Parent 1 Age: _____ Occupation: _____
Highest school grade completed: _____

ADDRESS: _____CITY:_____STATE:_____ ZIP:_____

EMAIL ADDRESS: _____ DO YOU CHECK THIS REGULARLY? _____

DAY PHONE: (_____)_____EVE PHONE: (____)_____CELL PHONE:(____)_____

Parent 2 Age: _____ Occupation: _____
Highest school grade completed: _____

ADDRESS: _____CITY:_____STATE:_____ ZIP:_____

EMAIL ADDRESS: _____ DO YOU CHECK THIS REGULARLY? _____

DAY PHONE: (_____)_____EVE PHONE: (____)_____CELL PHONE:(____)_____

Child lives with both parents Y/N
One Parent Y/N

Siblings? Y/N
If yes, please list names and ages.

_____ _____

_____ _____

_____ _____

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Please list any relatives on either side of the family who have had the following diagnoses. Please specify the relationship (e.g. mother, father, sibling, maternal aunt, etc.)

Attention disorders:

_____

Behavior problems:

_____

Emotional problems:

_____

Learning problems (including non-verbal learning disabilities)

_____

_____

Hearing problems (other than related to advanced age)

_____

Autism spectrum disorders:

_____

_____

Speech/language problems:

_____

_____

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 AUTHORIZAED 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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Background

What languages are spoken in your home? _____

Current School? _____

_____Last Grade Completed _____

Please describe your child's school experience: _____

Medical History

	YES	NO
Newborn		
Any complications	____	____
Cried right away	____	____

Please comment on anything above, which is considered atypical:

_____

	YES	NO
Infancy		
Enjoyed cuddling	____	____
Fussy/Irritable?	____	____

Please comment on anything above, which is considered atypical:

_____

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	YES	NO
Does your child have allergies or are allergies suspected?	____	____
Was development of teeth normal?	____	____
Does your child have difficulty with attention?	____	____
Has your child had ear infections? Were antibiotics effective in treating the problem?	____	____
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 retell stories or experiences that can be understood?	____	____
Does (s)he often hesitate and/or repeat sounds and words?	____	____

Please comment on anything above, which is considered atypical:

_____

_____

_____

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

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 _____ ?

List any medications, and doses, taken at present.

_____

_____

Additional Comments to Help Us Better Understand Your Child:

_____

_____

_____

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

Milestone	*Age*	*Comments*
Babbling	_____	_____
Imitating Words	_____	_____
Using first word meaningfully	_____	_____
Putting words together	_____	_____

Social Development

Does your child …	**Frequently**	**Sometimes**	**Almost Never**	**N/A**
get along with siblings?				
get along with other children?				
behave with adults?				

Hearing and Vision

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 wear glasses?

For reading? YES NO

For distance? YES NO

Additional Comments? _____

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Academic History

Does your child receive special remedial services and/or speech language therapy in school?
Yes No

Additional Comments:

Has your child repeated any grades? If yes, please list grade and reason.
Yes No

Has your child had any other problems in school? If yes, when did these problems start? Please describe.
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.