2009 SPEECH Patient Registration

DTI #_____ DATE: _____

Child's Last Name:_____ First_____ M.I._____

Date of birth:_____ Age:_____ M ≤ F ≤ Child's SS#_____

Primary Doctor:_____ Dr. Phone # _____
Address:_____ City:_____ State:_____ Zip Code_____

Referring Doctor:_____ Dr. Phone #_____

BILLING INFORMATION

Marital Status: Single ≤ Married ≤ Divorced ≤ Separated ≤ Foster Parent ≤
Child lives with whom:_____
Legal Guardian of Child:_____
Please show guardianship/custody papers if you are divorced, if you adopted the child, or if child is in foster care.

MAKE ANY NECESSARY CHANGES BELOW

Father's Name:_____
Birth date:_____
Address:_____
City:_____ State: _____ Zip Code:_____
Home Phone:_____
Employer:_____
Occupation:_____
Business Phone:_____
Business Address:_____
City:_____ State:_____ Zip Code:_____
Social Security #:_____

Mother's Name:_____
Birth date:_____
Address:_____
City:_____ State: _____ Zip Code:_____
Home Phone:_____
Employer:_____
Occupation:_____
Business Phone:_____
Business Address:_____
City:_____ State:_____ Zip Code:_____
Social Security #:_____

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MAKE ANY NECESSARY CHANGES BELOW

Support Coordinator:_____ _____
Coordinator's Phone #:_____ _____
Nearest Living relative or friend:_____ _____
Relative/Friend Phone #:_____ _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Insurance Name:_____ _____
If AHCCCS, plan name:_____ _____
Policy Holder:_____ _____
Identification # / SS#:_____ _____
Group #_____ _____
Effective Date:_____ _____
Insurance Co. Address:_____ _____
City:_____State:_____Zip Code:_____ _____
Insurance Co. Phone #:_____ _____

SECONDARY INSURANCE CARRIER

Insurance Name:_____ _____
AHCCCS Plan:_____ _____
Policy Holder:_____ _____
Identification # / SS#:_____ _____
Group #_____ _____
Effective Date:_____ _____
Insurance Co. Address:_____ _____
City:_____State:_____Zip Code:_____ _____
Insurance Co. Phone #:_____ _____

Is your child covered by any other insurance policies: YES ☐ NO ☐

Authorization to treat: I authorize Desert Therapies, Inc. to provide home-based speech therapy to my child.
Authorization to release information: I authorize the release of any medical or other information necessary to process any Speech Therapy claims.
Authorization to pay benefits to Desert Therapies: I authorize payment of medical benefits for Speech Therapy services provided by Desert Therapies, Inc. to Desert Therapies, Inc.

Signature Date