

Alaska Speech & Hearing Clinic

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Anchorage, AK 99508-5228
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www.akspeechclinic.com

Intake Form: Child

Legal name First _____ MI ___ Last _____
Preferred/nickname: First _____ MI ___ Last _____
Date of Birth _____ Social Security # _____
Mailing Address _____ City _____ State ___ Zip _____
Physical Address _____ City _____ State ___ Zip _____
Home Phone _____ Parent Work Phone _____ Parent Cell Phone _____
Parent Email Address _____

Primary Physician

Name: _____ Address: _____
Phone: _____ Clinic name: _____

SERVICES TO BE PROVIDED

Speech / Language Therapy _____ Audiology _____
Reason for Today's Visit/ Concerns: _____
Referral Source: ___ Physician ___ Friend ___ Insurance Company ___ Advertisement ___ other
Please name: _____

PARENT INFORMATION

Mother's Name _____
Address _____
Patient Lives with: YES NO
Home Phone _____ Work Phone _____ Cell Phone _____
Mother's preferred contact (8:00am-6:00pm): Cell phone ___ Home phone ___ Work phone ___
Name of Employer _____
Address _____ City/State/Zip _____
OK to Call (8:00am-6:00pm)? YES NO Best Time to Call _____
Parenting Status: Natural Adoptive Foster Other:

Father's Name _____
Address _____
Patient Lives with: YES NO
Home Phone _____ Work Phone _____ Cell Phone _____
Father's preferred contact (8:00am-6:00pm): Cell phone ___ Home phone ___ Work phone ___
Name of Employer _____
Address _____ City/State/Zip _____
OK to Call (8:00am-6:00pm)? YES NO Best Time to Call _____
Parenting Status: Natural Adoptive Foster Other:

EMERGENCY CONTACT

Name _____ Relationship to Patient: _____
Address _____ City/State/Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

ADDITIONAL CONTACTS

Legal Guardian (if not parent)/ Other/ Name: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Address _____ City/State/Zip _____

INSURANCE INFORMATION

PLEASE LIST ALL INSURANCE COMPANIES EVEN IF THEY WILL NOT COVER

Primary Insurance (attach copy of insurance card):

Insurance Company Name _____ Eligibility dates: _____
Insured's Name _____ Phone _____
Address _____ City/State/Zip _____
Date of Birth _____ Social Security # _____
Policy Number _____ Group Number _____
Relationship Self Spouse Child Other:
Insured / Subscriber Employer _____
Sex: Male Female Date of Birth _____
Is a referral / authorization required? Yes No (If yes, attach copy)

Secondary Insurance (attach copy of insurance card):

Insurance Company Name _____ Eligibility dates: _____
Insured's Name _____ Phone _____
Address _____ City/State/Zip _____
Date of Birth _____ Social Security # _____
Policy Number _____ Group Number _____
Relationship Self Spouse Child Other:
Insured / Subscriber Employer _____
Sex: Male Female Date of Birth _____
Is a referral / authorization required? Yes No (If yes, attach copy)

Tertiary Insurance (attach copy of insurance card):

Insurance Company Name _____ Eligibility dates: _____
Insured's Name _____ Phone _____
Address _____ City/State/Zip _____
Date of Birth _____ Social Security # _____
Policy Number _____ Group Number _____
Relationship Self Spouse Child Other:
Insured / Subscriber Employer _____
Sex: Male Female Date of Birth _____
Is a referral / authorization required? Yes No (If yes, attach copy)

Signature of Patient (or parent/legal guardian if under 18): _____

Printed name _____ for _____ Please print patient name

Date Signed _____

Please continue the child's registration process and complete the HIPAA Privacy Notice, Release of Information, and Medical History below. Thank you!