

Alaska Speech & Hearing Clinic

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Anchorage, AK 99508-5228
Phone: (907) 562-4550
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www.akspeechclinic.com

Patient Intake Form: Adult

Legal name First _____ MI _____ Last _____
Preferred name (nickname): First _____ MI _____ Last _____
Date of Birth _____ Social Security # _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____
Gender: M F Marital Status: Single Divorced Married Widowed Separated

Employer _____
Address _____ City/State/Zip _____

Primary Physician _____ Address _____

(MUST LIST ALL INSURANCE—EVEN IF THEY DO NOT COVER SERVICES)

Primary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligibility Dates: _____
Insured / Subscriber Information: _____
Relationship: Self Spouse Child Other:
Insured / Subscriber Employer: _____
Name of Insured _____
Address _____ City/State/Zip _____
Phone Number _____
Date of Birth _____ Sex: Male Female
Contact / Case Mgr: _____ Phone Number _____
Is a referral / authorization required? Yes No (If yes, attach copy if you have it)

Secondary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligible From: _____
Insured / Subscriber Information: _____
Relationship: Self Spouse Child Other:
Insured / Subscriber Employer: _____
Name of Insured _____
Address _____ City/State/Zip _____
Phone Number _____
Date of Birth _____ Sex: Male Female
Contact / Case Mgr: _____ Phone Number _____
Is a referral / authorization required? Yes No (If yes, attach copy)

Tertiary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligible From: _____

Insured / Subscriber Information: _____

Relationship: Self Spouse Child Other: _____

Insured / Subscriber Employer: _____

Name of Insured _____

Address _____ City/State/Zip _____

Phone Number _____

Date of Birth _____ Sex: Male Female

Contact / Case Mgr: _____ Phone Number _____

Is a referral / authorization required? Yes No (If yes, attach copy)

Type of Service Requested:

Speech / Language Therapy Audiology

Reason for Today's Visit _____

How did you hear about us?

Physician Name: _____

Insurance Company: _____

Advertisement: _____

Internet search engine/link: _____

Are you requesting services for injuries resulting from an accident?

Work _____ Auto _____ Other _____ None _____

PRESCRIPTION INFORMATION - Please attach a copy of any current prescriptions

Emergency Contact

NAME _____ PHONE _____

ADDRESS _____

Do you speak English? Yes No Do you understand English? Yes No

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

Date Signed _____

Printed name

RELEASE OF INFORMATION

I would like a copy of my hearing test, speech evaluation or other medical records to be shared with the following Physicians or providers:

Signature _____

Date _____

HIPAA NOTICE

I was given ASHC HIPAA Notice and I reviewed this notice. I was offered a copy for my records

Signature _____

Date _____

Patient or Child's Name: _____ Date of Birth: _____

Please Print