Anderson-Smith
SPEECH THERAPY LLC
Play with Purpose

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605-271-1852

Patient name: _____ Parent/Guardian: _____

DOB: _____ Age: _____

Address: _____
Phone (H): _____ Phone (W): _____
Phone (C1): _____ Phone (C2): _____
Emergency Contact Name and Number: _____
OK to text Yes ☐ No ☐
Email address(es): _____
Referring Physician: _____ Phone:_____
Fax: _____ Hospital affiliation: _____
How did you hear about us?: _____
Parent concerns: _____
_____
_____
Current Dx: _____ Who diagnosed and when? _____
Do you have a report? Yes ☐ No ☐ Available to send to office? Yes ☐ No ☐
Does your child have an IEP? Yes ☐ No ☐ Last IEP renewal date: _____
Do you have reports? Yes ☐ No ☐ Available to send to office? Yes ☐ No ☐
Services your child currently receives/who is providing services:
_____
_____

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Primary Insurance: _____
Name of Policy Holder: _____ DOB: _____
Claim, Policy or ID#:_____ Group #:_____
Ins. Co. Phone #:_____ Rep: _____
Ins. Co. Fax #: _____
Secondary Insurance: _____
Name of Policy Holder: _____ DOB: _____
Claim, Policy or ID#:_____ Group #:_____
Ins. Co. Phone #:_____ Rep: _____
Ins. Co. Fax #: _____