Owned and Operated By Speech Language Pathologists

Patient Intake Form

Patient Name: _____

If Minor, Parents Name: _____

Mailing Address: _____

Email: _____

Home Phone_____ Cell Phone_____ Work_____

Client's Date of Birth: _____

Who referred you? _____

INSURANCE INFORMATION:

Primary Insurance Co. Name_____

Insurance Address_____

Subscriber's Name _____ ID #_____

Subscriber's Birthdate: _____

Group Name _____ Group #_____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process these claims. I also authorize payment of medical benefits to the provider for services described.

Signed_____Date_____

8229 Boone Blvd Suite 660
Vienna, VA 22182

405 8th St NE Washington
Washington, DC 20002
www.readingllcenter.com

EIN 26-0060915
(703) 821-1363