Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
(281) 232-1900
speechtherapyplus@att.net

Patient Information:

Last Name: ______________________________ First Name: _____________________ Middle Initial: ___

Address: ____ Apt. #_________

City: __________________________________ State: _____________ Zip Code: _________________

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: _______________________________ Fax: _____________________________________

Email Address: ____

Patient's Date of Birth: _________________ **Parent SSN:** ________________________ Patient's Sex: M or F

Parent/Guarantor Name____

Primary Insurance Information:

Insurance Company: ____

Subscriber #: ____ Group #: _______________________

Name of Insured: _____________________________________ D.O.B. of Insured: _________________

Employer of Insured: ___________________________________ Work Phone: ____________________

Employer Address: ____

Work Status (circle one): Full Time Part Time Retired Unemployed

Secondary Insurance Information:

Insurance Company: ____

Subscriber #: ____ Group #: _______________________

Name of Insured: _____________________________________ D.O.B. of Insured: _________________

Employer of Insured: __________________________________ Work Phone: ____________________

Address of Employer: ____

Work Status (circle one): Full Time Part Time Retire Unemployed

Emergency Contact Information:

Name: ____ Relationship: _____________________

Home #: ____ Cell #: __________________________

Address: ____

Who should we thank for referring you to us? ____

Current Physician / Pediatrician: ____

Address: ____

Phone No: _____________________________________ Fax: __________________________________

I authorize Speech Therapy Plus, pllc. to bill my insurance company. I understand that I am financially responsible for charges, whether or not paid for by my insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ____ Date: ______________________