CENTER FOR HEARING & SPEECH
CELEBRATING A CENTURY OF SERVICE · 1920-2020

CLIENT REGISTRATION

(Please print clearly on both sides of the form)

Client Name _____ Birth Date: _____

Last First MI

[ ] Male [ ] Female Race/Ethnicity: _____ [ ] Decline Primary Language _____

Do you need an interpreter? [ ] Yes [ ] No Do you have a preference for interpreter? [ ] Male [ ] Female [ ] no preference

Address _____

Street City State Zip County

Home Phone _____ Work _____ Mobile _____ Other _____

My primary phone is □ H □ W □ M □ O Preferred way to receive appointment notifications [ ] Text [ ] Phone [ ] Email

Email address _____ Are you a U.S. Veteran? [ ] Yes [ ] No

If the client is a child, name of child's parent(s) or guardian(s) _____

Address if different than child _____

Do you live in a nursing home, retirement home, group home or rehab center? [ ] Yes [ ] No

If yes, what is the name of the facility? _____

Is there a contact person we should talk to? _____ Phone _____

Do you have a guardian or power of attorney other than parent listed above? [ ] Yes [ ] No

If yes, what is their name? _____ Phone _____

Who is your primary physician? _____ Phone _____

If referred here by a physician, what is their name? _____ Phone _____

Do you give permission for the Center to speak to these physicians about your services and condition? [ ] Yes [ ] No

Do you have insurance? [ ] Yes [ ] No

PRIMARY INSURANCE INFORMATION:

Insurance Company Name _____ Insured's Name _____

Address and phone if different from client _____

Patient Relation to Insured _____ Insured Date of Birth _____

ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name _____ Insured's Name _____

Address and phone if different from client _____

Patient Relation to Insured _____ Insured Date of Birth _____

ID # _____ Group # _____

IF YOU HAVE ANY ADDITIONAL INSURANCE, PLEASE NOTIFY US.

CENTER FOR HEARING & SPEECH

PEDIATRIC CASE HISTORY

Please fill out as much of the information as you can and return to _____. This information will be kept strictly confidential. If more space is needed, use the back of the form. If a question does not apply to your child, write N/A.

Child's Name:_____ **Date of Birth:** _____

Parent Signature: _____ **Date:** _____

HEALTH:

Please describe your child's health history.

_____

_____

_____

When your child was born, was there anything unusual about the delivery? _____ If yes, please explain.

_____

_____

What was your child's weight at birth? _____ Was your child premature? _____

Has your child had any ear infections or PE tubes? _____ If yes, when was the last ear infection and / or tubes placement? _____

Has your child had a hearing test? _____ Passed or failed the hearing test? _____ Date: _____

Please describe your child's current health.

_____

_____

_____

Is your child allergic to anything? _____

DEVELOPMENTAL HISTORY:

How old was your child when he / she started talking? _____

How old was your child when he / she started walking?_____

SPEECH AND LANGUAGE

Please describe what your concerns are: (i.e. speech sounds, understanding and using spoken or written language, voice problems, stuttering)_____

_____

Please indicate any other factors you would like to discuss in more detail._____

_____

_____

Has your child received previous speech evaluations or therapy? _____ If so, please list dates and places where services were received._____

_____

Are any languages other than English spoken in the home? Yes / No
If so, what language(s):_____Does the child speak this language? Yes / No
Does the child understand this language? Yes / No

How did you hear about the Center for Hearing & Speech? _____

For Audiology clients, we use patient photographs for medical record identification purposes. If you ***do not*** wish to have your photo taken please check this box. □

We are responsible to organizations that contribute financially to our programs. They want to know that we are providing services to individuals at all income levels. Names are never included in our reports. Please assist us by marking your household income level below.

[ ] under $19,999 [ ] $20,000 - $49,999 [ ] $50,000 - $74,999 [ ] $75,000 - $99,999 [ ] $100,000+

Number of people living in your household _____ Are you employed? [ ] Yes [ ] No

Alternate Contact: Name _____

Relationship _____ Phone _____ Alt. Phone _____

Other than the people you have already listed, who can we talk with about your services and/or condition?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I authorize the Center for Hearing & Speech to provide services for myself or the client named on this registration.

I authorize the release of all information necessary to process claims related to care provided to me by the Center for Hearing & Speech and authorize the Center to apply for benefits on my behalf and authorize my insurance company to send payment directly to the Center. I certify that the information reported is accurate and permit a copy of this authorization to be used in place of the original.

I understand that the HIPAA and privacy policies of the Center for Hearing & Speech can be found on the website, www.chsstl.org.

I authorize the Center to talk with the people listed on this form.

This release is valid until I provide a written statement revoking my authorization.

I understand that I am responsible for paying the cost for services I receive and for any charges my insurance/payer does not pay. I understand that payer sources may audit records to verify services were provided. Tardiness of more than 15 minutes or more may require you to reschedule. Less than 24 hour notice to cancel an interpreter will result in a charge.

Signature _____ Date _____

Thank you for choosing the Center for Hearing & Speech

6/2020