SUPREME SPEECH
THERAPY FOR ADULTS

HEATHER BERNER
M.S. CCC-SLP

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# Intake Form

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First Name: _____ Last Name: _____
Gender: _____ Birthdate: _____ Today's Date: _____

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____

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## Responsible Party

Name: _____ Relationship: _____
Email: _____ Phone Number: _____

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## Health Information

Primary Physician: _____ Physician Phone: _____
Diagnosis 1: _____ Diagnosis 2: _____
Diagnosis 3: _____ Diagnosis 4: _____
Hospitalization Date/Reason: _____

## Insurance Information

Medicare Number: _____ Social Security Number: _____
Other Insurance Provider: _____ Phone Number: _____
Policy Number: _____

Patient Name _____ Patient Signature_____ Date_____