Communicate
Therapy Services, LLC

Patient Information

Name: _____ Today's Date: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____

Parent/Guardian(s) name: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ Home Phone: _____

☐ Work Phone: _____

☐ Cell Phone: _____

☐ E-mail: _____

Preferred method of contact ☐phone ☐text ☐email

Primary Care Physician's Name: _____

Primary Care Physician's Address/practice: _____

City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____

Address (if different from patient address): _____

Phone number (if different from patient phone): _____

Emergency Contact _____ Phone Number: _____

How did you hear about us? ☐ Doctor ☐ Friend/Family Member ☐ School ☐ other_____

Insurance Information

Please provide a copy of your insurance card

Primary Insurance: _____

Policy Holder Name: _____

Group Number: _____ Phone Number: _____

Secondary Insurance: _____

Policy Holder Name: _____

Group Number: _____ Phone Number: _____