Madison Speech Associates
Registration Form

Please complete form as accurately as possible. This information is kept confidential.

Today's Date: _____

Patient Information:

Name: _____ _____ _____ Preferred Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: M F

Address: _____
(Street) (City) (State) (Zip)

Preferred phone number for contacting: _____ Email: _____

Parent/Guardian Information: (If patient is a minor)

Mother: _____ Date of Birth: _____

Address: _____

Phone: (home): _____ (cell): _____ (work): _____

Email address: _____ Occupation: _____

Father: _____ Date of Birth: _____

Address (if different from above): _____

Phone: (home): _____ (cell): _____ (work): _____

Email address: _____ Occupation: _____

Insurance Information: (For all patients)

Person responsible for bill: _____ DOB: _____

Address (if different than patient's): _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Primary Insurance: _____ Policy #: _____

Subscriber's name: _____ Subscriber's DOB: _____

Patient's relationship to subscriber (please circle): self spouse child other_____

Secondary insurance: _____ Policy #: _____

Subscriber's name: _____ Subscriber's DOB: _____

Patient's relationship to subscriber (please circle): self spouse child other_____

Emergency Contact: (For all patients)

Contact in case of an emergency (other than parent if patient is a minor): _____

Relationship to patient: _____

Phone: (Home) _____ (Work) _____(Cell) _____

Address: _____

Referral Information: (For all patients)

Referred by: _____

History of problem: _____

_____

_____

Have there been any significant changes in communication skills in the last six months? Yes No

If yes, please explain: _____

_____

Have you received any other therapy or evaluations? Yes No

If yes, please explain: _____

_____

Pregnancy/Birth History: (For patients under age 6)

Length of pregnancy: _____ Mother's age during pregnancy: _____

Please list any complications and/or prescribed medications during pregnancy, labor, or delivery:

_____

_____

_____

Were drugs or alcohol used during pregnancy? Yes No Type of delivery: C-section Vaginal

Birth weight of child: _____Length of Labor: _____

Number of days spent in the hospital: _____ NICU: _____

Medical History: (For all patients)

Please list any current medical issues: _____

_____

_____

Recent operations or accidents? _____

_____

Please list current medications:

Medication:	Reason for medication:

Hearing and Vision: (For all patients)

Last Hearing screen: _____ Last vision check: _____

Does the patient wear hearing aids? _____ Does the patient wear glasses? _____

Does the patient (if a minor) have a history of ear infections? _____

If so, what is the treatment? _____

Allergies: (For all patients)

Please list any allergies the patient may have: _____

_____

Developmental History: (For patients under age 6)

If your child is in school, please describe any difficulties or strengths in reading, writing or spelling:

_____

_____

Any special educations services received in school? _____

Describe any other concerns shared by the teacher if applicable:_____

_____

_____

Please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column.

MILESTONE	AGE	EARLY	ON TIME	LATE	Comments
Said first words					
Followed simple 1 step directions					
Said 2-3 phrases					
Knew colors					
Counted to 5					
Knew alphabet					
Potty Trained					
Weaned from bottle/breast					
Weaned from pacifier					
Does your child Thumb/finger suck? yes no					

Interest/ Hobbies/Other information: (For all patients)

_____

_____

_____

Communication goals: (For all patients)

What would you like to accomplish or improve in regards to communication skills?

_____

_____

_____