Sage®
Communication Clinic

Child - New Patient Form

Date: _____

Child Information

Child Name: First_____MI_____ Last_____ SS# _____

DOB:_____Sex: ▫ M ▫ F

Address: _____Apt # _____ City_____St_____Zip _____

Parent/Guardian Information

Parent's Name: First_____MI_____ Last_____ SS# _____

Age_____ Driver's License # _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

Employer:_____Occupation:_____ Business Phone #_____

E-Mail_____ Best Contact Method: ▫ Home ▫ Cell ▫ Work ▫ E-Mail ▫ Mail

Parent's Name: First_____MI_____ Last_____ SS# _____

Age_____ Driver's License # _____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

Employer:_____Occupation:_____ Business Phone #_____

E-Mail_____ Best Contact Method: ▫ Home ▫ Cell ▫ Work ▫ E-Mail ▫ Mail

Reason For Referral_____

Services Policy Agreement

Speech pathology services are provided for the patient with the understanding that payment for such services is solely the responsibility of patient, parent, or guardian. Sage Communication Clinic Inc. will cooperate in assisting the patient to secure insurance reimbursement for speech therapy services. By doing so Sage Communication Clinic makes no expressed or implied representation that your insurance company will in fact recognize speech pathology services as an allowed benefit to you.

PAYMENT IS REQUIRED AT THE TIME OF SERVICE.

Failed appointment and late cancellations will be billed out our regular session rate. I have read and agree to these policies.

Sign:_____Date:_____

FOR OFFICE USE ONLY

Diagnosis:_____

Additional Information:_____

Final Disposition:_____

Evaluation:_____Therapy:_____Therapist:_____

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(Continued)

Child Name: First_____Last_____ Age _____

Background Information

Please explain the primary reason for having your child evaluated: _____

_____

_____

_____

How long have you been concerned? _____

Does your child seem to be aware of the problem? ▫ Yes ▫ No

If "Yes" please explain your child's reactions or comments _____

_____

Health Information

Birth History:

Describe any complications in your pregnancy and/or delivery_____

_____

Child's Birth Weight:_____ Length of Pregnancy: _____

Describe your child's overall health: _____

_____

Pediatrician: _____Phone #_____

Please list other physicians or dentists currently treating your child: _____

_____

Has your child ever had an ear infection? ▫ Yes ▫ No

If "Yes" please explain frequency and treatment prescribed: _____

Is your child taking medications? ▫ Yes ▫ No

If "Yes" please explain:_____

_____

Has your child had any surgeries, accidents or allergies? ▫ Yes ▫ No

If "Yes" please describe:_____

_____

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(Continued)

When was your child's last hearing test?: _____Where? _____

Results? _____

Does your child seem to be aware of the problem? ▫ Yes ▫ No

Do you feel your child is experiencing any behavioral, social or emotional problems? _____

_____

Social Information

Please list the names and ages of everyone living in your home:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child speak any other languages? ▫ Yes ▫ No

If "Yes" please explain:_____

Is there a family history of any of the following?

Speech or Hearing Problems: ▫ Yes ▫ No
Learning Problems: ▫ Yes ▫ No
Birth Defects: ▫ Yes ▫ No
Emotional Problems: ▫ Yes ▫ No
Psychological Problems: ▫ Yes ▫ No

Name of School: _____Grade Level:_____

Describe your child's performance and adjustment to school:_____

_____

Other Information

How did you hear about Sage Communication Clinic? _____

Please provide the name(s) of any other specialists seeing your child:_____

_____

How can we be the most helpful to you? _____

_____

Person completing form: _____Date:_____

Relationship to Child: _____

Thank you for taking the time to complete this form