Memphis Speech and Hearing Center

Client Demographic Information

File #:	
Date:	

Please compl	ete all of the informa	ation on both side	s of this form.	
Client Inform	ation:			
Name:				
	Last	F	irst	M.
Address:	Street		City	State/Zip
Phone:				
	Home		Cell	Work
E-mail:		Date of Birth:		SS#:
Marital Status:	☐ Single ☐ Ma		☐ Divorced	\square Other
Gender:	☐ Male ☐ Fen			
Race/Ethnicity:	☐ Black ☐ Wh ☐ Other	ite 🗆 Hispanic	□ Asian □	Native American Biracial
Client Status:	☐ Full-time Student	☐ Part-time Stud	ent 🗆 Employ	yed □ Un-Employed/Retired
Religious Affilia	tion:			
Primary Physici	an:		Phone:	
Address:				
	Street		City	State/Zip
	rent/Legal Guardian: and/or custodial parent wil		nentation to verify	2
Address:	Last	F	irst	M.
	Street		City	State/Zip
Phone:	Home		Cell	Work
E-mail:	Home			ngle □ Separated □ Divorced
Parent 2 Name:				
	Last	F	irst	M.
Address: ☐ S	ame as Parent 1			
Dhana	Street		City	State/Zip
Phone	Home		Cell	Work
E-mail:		Marital Status	:□ Married □ Si	ngle □ Separated □ Divorced

CLIENT INSURANCE/BILLING INFORMATION

Please provide a copy of your insurance card

We must have this information to properly file the claim to the carrier

Emergency Contact:				
(Partner in Care)	Name	Phone 1	Phone 2	
Relationship to client:				
Please list the other persons	s, if any, whom may	transport individual to and /or fron	n Center:	
Name:		Phone:		
Name:		Phone:		
Name:		Phone:		
Billing Information:				
Responsible Party:	Last	First	M.	
Billing Address:	Last	FIISL	IVI.	
	Street	City	State/Zip	
Occupation:		Social Security #:		
Employer of Insured:				
	Name	Address	Phone	
Primary Insurance Informat	ion:			
Carrier Name:		Address:		
Phone #:		Group #:		
Policy ID:				
Policy holder's Date of Birth:		Social Security #:		
Secondary Insurance Inform	ation:			
Carrier Name:		Address:		
Phone #:		Group #:		
Policy ID:		Relationship to client:		
Policy holder's Date of Birth:		Social Security #:		