Schie SPEECH

# New Patient Registration

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ E-mail: _____

Sex: _____ Gender Identity: _____ Pref. Pronouns: _____

Marital Status: _____ Student: _____

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**Please complete if patient is under the age of 18:**

Parent/Guardian: _____ Relationship: _____

Telephone Number: _____ E-Mail: _____

Child Custody Status:

☐ Mother ☐ Father ☐ Joint Custody ☐ Legal Guardian

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**Insurance Information:**

Insurance Provider: _____ Subscriber ID: _____

Insured Party:(who is the insurance coverage under)

☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Child ☐ Other

Name: _____ DOB: _____

Patient Relation: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Schie SPEECH

# New Patient Registration

***Guarantor Information*: (if Under 18, who is financially responsible)**

Name: _____ DOB: _____

Patient Relation: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

**Emergency Contact: (if other than parent/guardian).**

Name: _____ Relationship: _____

Telephone #: _____