Southern Therapy Solutions
Phone: 229-560-6944
Fax: 888-450-0379
3256 North Valdosta Road
Valdosta, GA 31602
SouthernTherapyValdosta.com
southerntherapysolutions@gmail.com

Patient Information

Patients Name: _____ I prefer to be called: _____
Date of Birth: ____/____/_____ Sex: Male or Female (circle)
Cell Phone: (____)_____ Work Phone: (___)_____
Address: _____City:_____State:_____Zip_____
Driver's License # _____ Appointment Availability: M T W TH F – AM or PM
Father's Name: _____ DOB: ___/___/_____
Home #: (____)_____ Cell#: (____)_____ Work #:(____)_____
Mother's Name: _____DOB: ___/___/_____
Home #: (____)_____ Cell#: (____)_____ Work#: (____)_____
Person to contact in case of emergency: _____Phone: (____)_____
The best time to contact me is: _____ A.M.___ P.M.___ on: Home___ Work___ Cell phone ___
Circle appropriate option for patient: Minor Single Married Widowed Separated Divorced
If Student, Name of School_____ City/State_____ FT___ PT___
Does your child receive therapy services in the School System? Yes or No (If yes, please fill out page 3)
Has your child received speech therapy services at another clinic? Yes or No (If yes, please fill out page 4)
Primary Physician's Name: _____ Phone: (_____)_____
Referring Physician's Name: _____ Phone: (_____)_____
Insurer Information:
Relationship to Patient: Self ____ Spouse ____ Parent ____ Other ____
Name: _____ Phone: (____)_____
Address: _____City:_____State:_____Zip_____
Email Address:_____
SSN#_____Employer_____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. If for any reason any portion is not paid for by my insurance, I agree to make arrangements for prompt payments of the account. I have read all the above information and have completed the above answers truthfully and correctly. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status regarding the above information.

_____ _____
Signature of Patient (Parent or Guardian if a Minor) Date

Initial: ___

Insurance Information

Please provide a copy of your medical insurance card(s) to the receptionist.

Patients Name: _____Date of Birth: ____/____/_____

Primary Insurance

Name of Policy Holder: _____ DOB: ___/___/_____

Relationship to Patient: _____ SSN#: _____

Name of Employer:_____ Work Phone: (____)_____

Insurance Company: _____

ID#: _____ Group #: _____

Ins. Co Address: _____ City: _____ State: ____ Zip: _____

Ins. Co. Phone: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes ____ No ____ IF YES, COMPLETE THE FOLLOWING SECONDARY INSURANCE INFORMATION

Secondary Insurance

Name of Policy Holder: _____ DOB: ___/___/_____

Relationship to Patient: _____ SSN#:_____

Name of Employer:_____ Work Phone: (____)_____

Insurance Company: _____

ID#: _____ Group #: _____

Ins Co Address: _____ City: _____ State: ____ Zip: _____

Ins. Co. Phone: _____

Initial: ___