

# ADVANTAGE SPEECH THERAPY SERVICES, INC.

## PATIENT INFORMATION FORM

### DIRECTIONS:

1. PLEASE FILL IN ALL APPROPRIATE FIELDS AS IT APPLIES TO YOU
2. SIGN THE HIGHLIGHTED SECTION.
3. **PLEASE PROVIDE ASTS WITH A COPY OF YOUR INSURANCE CARD(S)!**  
THANK YOU!

PATIENT INFORMATION		
CHILD'S FULL NAME _____	_____	MALE / FEMALE _____
DATE OF BIRTH: _____	AGE: _____	_____
ADDRESS: _____	_____	_____
CITY: _____	STATE: _____	ZIP CODE: _____
APT. COMPLEX (if applicable): _____	APT # / BLDG # _____	_____
HOME PHONE #: _____	_____	_____
DOCTOR INFORMATION		
REFERRING DR.'S OFFICE/PRACTICE: _____	_____	_____
ADDRESS _____	_____	_____
DR'S PHONE #. _____	FAX # _____	_____
DIAGNOSIS (IF KNOWN): _____	_____	_____
PARENT / GUARDIAN INFORMATION		
MOTHER'S NAME: _____	DATE OF BIRTH: _____	_____
EMPLOYER: _____	_____	_____
WORK #: _____	CELL: _____	_____
EMAIL: _____	_____	_____
FATHER'S NAME: _____	DATE OF BIRTH: _____	_____
EMPLOYER: _____	_____	_____
WORK #: _____	CELL: _____	_____
EMAIL: _____	_____	_____
PRIVATE INSURANCE INFORMATION (IF APPLICABLE)		
INSURANCE ELIGIBILITY EFFECTIVE DATE: _____	ENDING DATE: _____	_____
INSURANCE POLICY HOLDER: (I.E. MOTHER/FATHER) _____	_____	_____
INSURANCE NAME: _____	_____	_____
INSURANCE ADDRESS: _____	_____	_____
_____	_____	_____
INSURANCE PHONE #: _____	_____	_____
INSURANCE ID #: _____	_____	_____
GROUP #: _____	_____	_____
GEORGIA MEDICAID INFORMATION (IF APPLICABLE)		
MEMBER IDENTIFICATION #: _____	_____	_____
MANAGED CARE CO. <i>PLEASE CIRCLE ONE</i> (CHOOSE FROM - AMERIGROUP, WELLCARE, PEACH STATE)	_____	_____
BABIES CAN'T WAIT INFORMATION (IF APPLICABLE)		
SERVICE COORDINATOR'S NAME: _____	PHONE #: _____	_____
COUNTY: _____	COST PARTIC: <i>BCW</i> : _____	% PARENT: _____ %
<b>THE ABOVE STATED INSURANCE WILL BE BILLED IN THE ORDER LISTED, AS APPROPRIATE, HOWEVER, THE ABOVE LISTED MOTHER, FATHER, GUARDIAN AND/OR INSURED PARTY ARE FULLY RESPONSIBLE FOR ANY BALANCE DUE AND/OR UNPAID SERVICES.</b>		
PRINT NAME _____	SIGNATURE _____	DATE _____

**\*\*ASTS USE ONLY\*\*** DATE SUBMITTED FOR VERIFICATION: \_\_\_\_\_  
START OF CARE DATE: \_\_\_\_\_

*Advantage Speech Therapy Services, Inc.*

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