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. *PLEASE CIRCLE ONE* (CHOOSE FROM – AMERIGROUP, WELLCARE, PEACH STATE)

BABIES CAN'T WAIT INFORMATION (IF APPLICABLE)

SERVICE COORDINATOR'S NAME: ___________________________ PHONE #: _______________
COUNTY: ______________________ COST PARTIC: *BCW*: _______ % *PARENT*: ________%

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.

____________________________ ____________________________ ________________
PRINT NAME *SIGNATURE* *DATE*

****ASTS USE ONLY **** DATE SUBMITTED FOR VERIFICATION: ______________________________
START OF CARE DATE: ____

Advantage Speech Therapy Services, Inc.
1151 Dunedin Trail • Woodstock, Ga 30188 • fax 770-517-0982 • Email:advantagespeech@me.com