CHICO SPEECH AND LANGUAGE CENTER

2627 Forest Avenue
Chico, CA 95928
(530) 894-0702 Fax (530) 894-0905

Patient Information

Name_____ Pronouns_____ Date_____ Sex: ☐M ☐F

Date of Birth _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If patient is a minor, please provide the following information for the parent:
Name _____ E-mail _____ Date of Birth _____

Address_____
City_____ State_____ Zip_____ Phone_____

E-mail_____ Can we contact you through text, call, and email? ☐ Yes ☐ No

Would you like to sign up for Patient Portal? ☐ Yes ☐ No

Occupation_____ ☐ Full ☐ Part Time
Employer_____ Employer Phone_____
Employer Address_____
Spouse's Name_____ Spouse's email_____ Date of Birth_____
Spouse's Occupation_____ Employer_____
Employer Address_____ Phone_____
Whom may we thank for referring you?_____

Insurance Information

Who is responsible for this account?_____ Relationship to Patient_____
Insurance Company_____
Address_____ City_____ State_____ Zip_____
Policy #_____ Group #_____

Is the patient covered by additional insurance? ☐Yes ☐No If yes, please complete the following:
Secondary Company_____
Address_____ City_____ State_____ Zip_____
Policy #_____ Group #_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chico Speech and Language all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date