HILL NEUROGENIC SPEECH-LANGUAGE PATHOLOGY, PLLC
www.hillneuroslp.com | 248.973.7355

PATIENT IN-TAKE FORMS

Patient Name: _____
Last First

Date of Birth: _____ Age:_____
MM/DD/YY

Home Address: _____
Street

_____ _____ _____
City State Zip Code

Phone Number: _____
Cell

_____
Home

Email Address: _____

Emergency Contact(s)

1st contact: _____ _____
Name: Last, First Relationship

2nd contact: _____ _____
Name: Last, First Relationship

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PATIENT IN-TAKE FORMS

Primary Care Physician: _____
Name

Address: _____
Street

_____ _____ _____
City State Zip Code

Phone Number: _____
Office

_____
Fax

Ear Nose & Throat Doctor:_____
Name

Address: _____
Street

_____ _____ _____
City State Zip Code

Phone Number: _____
Office

_____
Fax

Preferred Hospital in case of emergency: _____
Name

_____
City

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PATIENT IN-TAKE FORMS

Do you have a *Guardian/Durable Power of Attorney*?(please circle one if yes) _____ _____
Yes No

Name: _____ _____
Last, First Relationship

***** In accordance with HIPPA Laws, Legal documentation of Guardianship or Durable Power of Attorney is required as part of the patient's medical records at Hill Neurogenic Speech-Language Pathology, PLLC .***

Contacts you grant approval for Speech Therapist to share information pertaining to your rehabilitation (family, caregiver, etc) not medical doctor.

contact: _____ _____
Name: Last, First Relationship

contact: _____ _____
Name: Last, First Relationship

contact: _____ _____
Name: Last, First Relationship

contact: _____ _____
Name: Last, First Relationship