4153 Flat Shoals Parkway. Building C Suite 300A, Decatur, GA 30034

Office: 404-244-9477 Fax: 855-204-3767

Intake Form for Speech-Language Therapy

Date: **Patient's Name:** **Date of Birth:**

_____ _____ **Sex:** ___ _____

Parent's Name: _____

Home Address: _____

City: _____ **Zip Code:** _____

Phone Home: _____ **Cell:** _____

Email: _____

Name of Physician Office Practice/Group: _____

Prescribing Physician Phone and Fax: _____

Primary Insurance: (Circle One) Regular Medicaid (SSI) Amerigroup Aetna

UHC BCBS Wellcare Peachstate Private Pay CareSource Cigna

Medicaid Number: _____

Policy #_____ **Group#**_____

Private Insurance Address: _____

Parent/Guardian Concerns: _____

Does your child have an Individual Education Plan (IEP) or Individual Family Service Plane (IFSP) through Babies Can't Wait (BCW): YES NO

Referred by: _____

Initial Evaluation: _____
