Northeast Hearing & Speech
hear • speak • communicate

75 West Commercial Street, Suite 205
Portland, Maine 04101
Voice/TTY: 207/874-1065
Fax: 207/874-1068

ADULT CLIENT DATA SHEET

DATE: _____

CLIENT'S NAME: _____
First Name *Middle Initial* *Last Name*

DATE OF BIRTH: _____ **GENDER:** ☐Male ☐Female **SSN:** _____

ADDRESS: _____
Street *City* *State* *Zip Code*

PHONE: _____ _____ **EMPLOYER:** _____
Home *Cell* *Name* *Phone*

EMAIL ADDRESS: _____

CAREGIVER'S NAME *(if applicable)*: _____

REFERRED BY: _____ **REASON FOR REFERRAL:** _____

PRIMARY CARE PHYSICIAN: _____
Name of Practice/Location/Phone #: _____

INSURANCE INFORMATION: ***Please bring your insurance card(s) and ID to your appointment.***

Primary Insurance & Certificate Number: _____

Secondary Insurance & Certificate Number: _____

Person Responsible for payment after insurance Name/Address/Phone #: _____
_____

Please initial the following statements and sign:

_____ I authorize release of medical information necessary to process any insurance claims. I also authorize assignment of benefits to Northeast Hearing and Speech and agree to pay any balance not covered by my insurance.

_____ I understand that written reports will be sent to me (or my guardian) and may be sent to physicians involved in my ongoing medical care.

_____ I have reviewed Northeast Hearing and Speech's Notice of Privacy Practices (HIPAA policies). I understand that I may request a copy.

_____ **Date:** _____
Signature of Client / Legal Guardian (circle one) **If you are neither, please advise office staff.**

On the reverse side please list others that should receive a copy of written reports➔

Please send written reports to:

Name/Practice and Address: _____

_____

_____

Name/Practice and Address: _____

_____

_____