

Texas Tech University Health Sciences Center  
Speech, Language and Hearing Clinic  
3601 4<sup>th</sup> Street, Suite 2A300  
Lubbock, Tx 79430  
806-743-5678

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Male  Female   
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Mother  Stepmother  Guardian  
Name: \_\_\_\_\_ DL#: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SS#: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Father  Stepfather  Guardian  
Name: \_\_\_\_\_ DL#: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SS#: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

**PRIMARY INSURANCE** (please provide the information which is not on your insurance card)

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**ADDITIONAL INSURANCE**

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_