



Confidential Patient Information

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**NEW PATIENT REGISTRATION FORM**

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
LAST FIRST MI MO DAY YR

HOME PHONE: \_\_\_\_\_ SS#: \_\_\_\_\_

PATIENT #:(OFFICE USE) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN PHONE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN PHONE: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

Phonebook \_\_\_\_\_ Website \_\_\_\_\_ Friend \_\_\_\_\_ Doctor \_\_\_\_\_ Other \_\_\_\_\_

**RESPONSIBLE PARTY (PARENT/LEGAL GUARDIAN)**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST FIRST MI MO DAY YR

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST FIRST MI MO DAY YR

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_



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**INSURANCE**

**PRIMARY INSURANCE:** \_\_\_\_\_

POLICY NUMBERS: \_\_\_\_\_

(ID#) (GROUP/PLAN#)

POLICY HOLDER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

LAST FIRST MI

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MO DAY YR

INSURANCE PHONE: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

POLICY NUMBERS: \_\_\_\_\_

(ID#) (GROUP/PLAN#)

POLICY HOLDER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

LAST FIRST MI

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MO DAY YR

INSURANCE PHONE: \_\_\_\_\_

MINNESOTA MA: \_\_\_\_\_ YES \_\_\_\_\_ NO ID# \_\_\_\_\_

**RELEASE OF INFORMATION**

I authorize the exchange of Protected Health Information between Speech and Language Connections and the specified individuals listed below:

PRIMARY DOCTOR/CLINIC: \_\_\_\_\_

PHONE #: \_\_\_\_\_

SPECIALTY DOCTOR/CLINIC: \_\_\_\_\_

PHONE #: \_\_\_\_\_

PRESCHOOL/SCHOOL DISTRICT: \_\_\_\_\_

PHONE #: \_\_\_\_\_

OTHER: \_\_\_\_\_

PHONE #: \_\_\_\_\_

OTHER: \_\_\_\_\_

PHONE #: \_\_\_\_\_



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### OTHER CONTACTS

Please list other individuals who are involved in taking care of the patient, such as caregiver and/or relative other than guardian, with whom you authorize Speech and Language Connections. to discuss/exchange information regarding the patient's treatment.

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
LAST FIRST MI

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
LAST FIRST MI

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
LAST FIRST MI

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

### AUTHORIZATIONS and ACKNOWLEDGEMENTS

I have received the Notice of Privacy Practices from Speech and Language Connections.

SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent/Legal Guardian

I hereby authorize Speech and Language Connections to furnish information concerning treatments to INSURANCE CARRIERS, PHYSICIANS, and THERAPISTS AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to LeeAnn Kyriakides M.S. CCC-SLP DBA Speech and Language Connections. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X \_\_\_\_\_ DATE: \_\_\_\_\_  
Parent/Legal Guardian