Poynton-Marsh Speech Services
1632 Savannah Rd-Suite 5
Lewes, DE 19958
T 302-644-1220
F 302-827-4382

Who referred you to our office?____
Who is your primary care physician?____
Are you receiving home health services? No____Yes____ If so, agency________________

PATIENT INFORMATION Today'sDate:________________

Patient's Name:____________________________________Male______ Female_________

Date of Birth:____________Current Age:_________Social Security #:________________

Occupation:______________________________Education:___________________________

Address: ____
(Street) (City) (State) (Zip)

Patient's Phone No.___________________ __________________ ____________________
(Home) (Work) (Cell)

Email address:____

I consent to be contacted by phone or text message by Poynton-Marsh Speech Services to be advised of appointments.
Yes_______ No_______

Emergency Contact:___________________________________Relation:_______________
Telephone:____

PRIMARY INSURANCE
Insured's Name:______________________________Relationship:_____________________
Date of Birth:________________________________SS#:_____________________________
Employer:____________________________________Employer Phone#:________________
Employer Address:____
Insurance Co:_________________________________Ins. Co. Phone#:________________
Policy#:_____________________________________Group #:_________________________
SECONDARY INSURANCE
Insured's Name:_____________________________Relationship:______________________
Date of Birth:_______________________________SS#:______________________________
Employer:___________________________________Employer Phone #:________________
Employer Address:____
InsuranceCo:________________________________Ins. Co. Phone#:_________________
Policy#:____________________________________Group #:________________________

MEDICAL HISTORY

	YES	NO		YES	NO
STROKE			PNEUMONIA		
TIA			DIABETES		
PARKINSONS DISEASE			MULTIPLE SCLEROSIS		
CANCER OR LEUKEMIA			ANXIETY		
HEART TROUBLE			DEPRESSION		
HYPERTENSION			VOCAL NODULES		
ASTHMA			HEARING LOSS		
COPD			WEIGHT LOSS		
EMPHYSEMA			DENTURES		

Other conditions or further explanation:____

____

____

SURGICAL HISTORY Pertinent to Today's Appointment

Type of Surgery	Date

CURRENT MEDICATION LIST

Prescription and Over the Counter	Dosage	Reason for Taking

Describe your speech-language-swallowing problem______________________________

____

____

____

When was the problem first noticed?____________________By whom?____________
Does the problem interfere with work/social activities?______If yes, explain______

____

Signature____Date________________
Reviewed by____Date________________