

UNIVERSITY OF SOUTH ALABAMA  
DEPARTMENT OF SPEECH PATHOLOGY  
AND AUDIOLOGY

\_\_\_\_\_  
Account Number  
\_\_\_\_\_  
Physician/Therapist  
\_\_\_\_\_  
Referring Physician

SECTION A: PATIENT INFORMATION

NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP  
SOCIAL SECURITY NUMBER \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_ Can we use this address to  
communicate with you regarding health information? \_\_\_\_\_

SECTION B: SPOUSE I RESPONSIBLE PARTY

NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP  
SOCIAL SECURITY NUMBER \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
EMPLOYER \_\_\_\_\_