



# Blue Ridge Speech and Hearing Center

19465 Deerfield Ave., Suite 201

Lansdowne, VA 20176

PHONE: 703-858-7620 FAX: 703-858-7657

Patient Name: \_\_\_\_\_  
First Middle Last

Permanent Address: \_\_\_\_\_  
(Not PO BOX) Street City, State, Zip

Mailing Address \_\_\_\_\_  
(if different from above) Street City, State, Zip

Social Security #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex  Male  Female

Marital Status:  Single  Married  Separated  Divorced  Other

### Patient Employment Information (if patient is a minor, parent complete):

Employee / Father's Name \_\_\_\_\_

Place of Employment / Occupation \_\_\_\_\_  
Name City, State Occupation Telephone

Employee / Mother's Name \_\_\_\_\_

Place of Employment / Occupation \_\_\_\_\_  
Name City, State Occupation Telephone

Who referred you to this office? \_\_\_\_\_

Nearest Relative \_\_\_\_\_  
(Not at same address) Name Telephone

### INSURANCE INFORMATION:

Private Pay  Insurance

Primary Insurance Co. Name / Address \_\_\_\_\_  
Name Address City, State, Zip

Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Co. Name / Address \_\_\_\_\_  
Name Address City, State, Zip

Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process these claims. I also authorize payment of medical benefits to the provider for services described

Signed \_\_\_\_\_ Date \_\_\_\_\_

If you do not want to receive information about new services, fundraising events or other BRSB news, please check here