

**Jill Russell, MS/CCC-SLP**  
**Patient Registration**

Patient's Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex M/F

Mother's Name (First \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Driver's License# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_

Father's Name (First \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Driver's License# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
Phone _____	Address _____
Group# _____	Group# _____
ID# _____	ID# _____
Subscriber Name _____	Subscriber Name _____
Effective Date _____ Co-Pay _____	Effective Date _____ Co-Pay _____

**ASSIGNMENT OF BENEFITS AND AGREEMENT OF FINANCIAL RESPONSIBILITY:** I hereby assign to Jill Russell all insurance benefits due for services rendered. I understand that I am responsible for balances as stated by my insurance company and that I am fully responsible for those services which are not a covered benefit of my insurance plan.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Jill Russell to release to the insurance company named above any information acquired in the course of my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Email address: \_\_\_\_\_