

**The Speech and Hearing Center**  
**600 N. Holtzclaw Ave – Suite 200**  
**Chattanooga, Tn. 37404 Telephone 423-622-6900**

Who referred you to our Center: \_\_\_\_\_

Patient's Name \_\_\_\_\_

File Number

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip) (County)

Patient's Phone No. \_\_\_\_\_  
(Home) (Work) (Cell Phone)

**E-mail address:** \_\_\_\_\_

**I Consent** to be contacted by Phone or a Message may be left on the answering machine by The Speech and Hearing Center to be advised of appointments. \_\_\_ Yes \_\_\_ No

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

\_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Race: Black \_\_\_\_\_ White \_\_\_\_\_

Hispanic \_\_\_\_\_ Other \_\_\_\_\_

<b>Family Yearly Income</b>
4,999 or Below _____
5,000 to 9,999 _____
10,000 to 19,999 _____
20,000 to 29,999 _____
30,000 or Above _____

Parent/Guardian or Spouse \_\_\_\_\_

(Name) (Phone) (Relation)

Other Contact-Nearest \_\_\_\_\_

(Name) (Phone) (Relation)

**PLACE OF EMPLOYMENT**

\_\_\_\_\_  
Father's Name Husband's Name Company Name Phone

\_\_\_\_\_  
Mother's Name Wife's Name Company Name Phone

**PAYMENT FOR SERVICES**

**Payment is expected at time of service. Patient (or his/her designated representative) is responsible for any and all charges for services rendered at this facility.**

**Person Responsible for charges, if other than patient.**

Signature \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_

PhoneNumbers \_\_\_\_\_  
(Home) (Work) (Cell Phone)