Speech & Language Therapy and Rehabilitation Specialists, LLC

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New Client Information

Date: ______________

Client Name: ____ Date of Birth: ________________

Address: ____ Age: ________ Gender: _______

____ Home Phone: ________________

If applicable to client:

Cell Phone: ___________________ Work Phone: __________________ E-mail___________________________

If Client is a minor:

Child Lives With: Both Parents ______ Mother _____ Father _____ Guardian:___________________

If Divorced, who has custody? Joint _____ Mother _____ Father _____ Other:______________________

Father's Name: ________________________________ Mother's Name: ________________________________

Address: ________________________________ Address: ________________________________

________________________________ ________________________________

Home Phone ________________________________ Home Phone: ________________________________

Cell Phone: ________________________________ Cell Phone: ________________________________

Work Phone ________________________________ Work Phone: ________________________________

E-mail: ____ E-mail: ____

Emergency Contact: Father ___ Mother ___

Other Emergency Contact: ________________________________ Relationship__________________________

Home phone: ______________________ Work: _______________________ Cell: __________________

Following completion of a session, STARS, LLC is authorized to release the client to the following individuals (if person dropping of client is different from person picking up):

Both Parents _____ Mother _____ Father _____ Guardian_____ Other_____ (please fill out below)

Name	Relationship	Cell Phone
_________________________	_____________________	_________________
_________________________	_____________________	_________________
_________________________	_____________________	_________________

I have read the STARS, LLC Financial Policy and I agree to abide by its conditions.

Signature _________________________________ **Date** ______________