



**Innovative Swallowing & Therapeutics LLC**  
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**PLEASE GIVE YOUR INSURANCE AND IDENTIFICATION CARDS TO THE RECEPTIONIST FOR COPYING**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Who may we contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Please list the prescription medications you are currently taking or provide us with a list to copy:


Please identify Guardian or Caregiver if applicable:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_