Patient Information

Sandra Emanuel, LCSW

Name:___________________________ Date of Birth: _________ Age: ____ Address:_____________________

City/State:_______________________ Zip: _______

Home Phone: _____________ Work Phone:_____________ Mobile Phone:_____________

SSN#:____________________

Is it OK to call you at Home? Y / N

Is it OK to call your Mobile? Y / N

Is it OK to call you at Work? Y / N

Is it OK to leave a message at Home? Y / N

Is it OK to leave a message at Home? Y / N

Is it OK to leave a message at Work? Y / N

Marital Status: (circle one) Married Single Divorced Separated Widow(er)

Employed by:____________________________________

Referred by:____________________________________

Primary Care Provider:__________________________

Are you here for Workers Comp? Y / N

Are you here for reasons related to a case currently in litigation? Y / N

Are you here for reasons related to an accident? Y / N

Name of Spouse(or Parent if patient is under 18): ________________________________

Address if different from above: ____

Spouse or Parent employed by: ____

Other family members in your home / Immediate family members outside of the home?

Name:___________________________ Relationship:___________Age:______ Health Issues: ___________________________

Name:___________________________ Relationship:___________Age:______ Health Issues: ___________________________

Person Responsible for the Bill

Name: ____________________ Date of Birth:___________ SSN#:________________

Address if not previously listed ____

Employed by: ____

Insurance Information

Insurance Company: ___________________________ Name of Insured ______________________

Address: ____

Phone: _____________ ID#:__________________Group#:__________________________

Insurance Authorization and Assignment

I HEREBY AUTHORIZE SANDRA EMANUEL, LCSW TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S) AND MY REFERRING PHYSICIAN CONCERNING MY ILLNESS AND TREATMENT. BY THIS AUTHORIZATION I GIVE PERMISSION FOR SANDRA EMANUEL, LCSW TO COMMUNICATE WITH MY INSURANCE COMPANY FOR THE PURPOSES OF ACQUIRING PRIOR APPROVAL AND/OR CERTIFICATION OF SERVICES RENDERED. I HEREBY ASSIGN INSURANCE BENEFITS PAYABLE TO SANDRA EMANUEL, LCSW FOR SERVICES RENDERED TO ME OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY PORTION OF THE FEES. I UNDERSTAND THAT I MAY ADDRESS ANY PROBLEMS OR CONCERNS WITH SANDRA EMANUEL, LCSW AND/OR MY INSURANCE CARRIER. I MAY DISCONTINUE TREATMENT AT ANY TIME.

____ ________________________

Signature of Patient or Legal Guardian Date:

Patient Information

Sandra Emanuel, LCSW

Reason for Appointment: ____
____
____

Please list any medications you are taking and the dosage:

____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________
____________________________________ ____________________________________

Do you have any Allergies: Y / N If so, Allergies to what? ___________________________________
____

Have you smoked Tobacco? Y / N How long? _________ Do you currently smoke? Y / N

Do you drink Alcohol? Y / N Average consumption? _______________________

Have you previously seen a Psychiatrist or other mental health professional? Y / N

If so, when and whom?____

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For Children and Adolescent Patients

Was the pregnancy normal? Y / N If no, what were the complications? _______________________________

At what age did the child walk? _________ Talk? _________ Toilet Train? _________

Current grade in school? _________ Special education services? Y / N

Is there any history of physical or sexual abuse? Y / N

Is there any history of Medical Problems? Y / N If so, what?_______________________________________

For Children and Adolescent Patients

I hereby request that (name)________________ DOB: ____________ be accepted for mental health treatment by Sandra Emanuel, LCSW

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Contact in case of Emergency

Name_____________________ Relationship______________ Phone: ____________

I AM AWARE THAT THE INFORMATION PROVIDED IS CONFIDENTIAL WITH THE EXCEPTIONS OF: (1) ANY INFORMATION RELATING TO PHYSICAL OR SEXUAL AUBSE WHICH REQUIRES A REPORT TO CYFD OR ANY INFORMATION THAT REQUIRES A REPORT TO ADULT PROTECTIVE SERVICES (2) THE LIKELIHOOD OF SUICIDE WHICH REQUIRES NOTIFICATION OF FAMILY OR LAW ENFORCEMENT (3) THE INTENT TO COMMIT A CRIME WHICH REQUIRES NOTIFICATION OF THE INTENDED VICTIM.

____ ____________________

Signature of Patient or Legal Guardian Date: