Thomas B. Allen II, Ph.D.
Suzanne D. Pascoe, LPC
Christie Hunnicutt, LCSW
Tracy A. Shiring, M.S. Ed
Tori Piraino, LCSW
Kelly Leach, LCSW
Lisa N. Backus, Ph.D.
Sarah A. Hallwood, LCSW
Christine Migdole, LCSW
Loren B. Sterman, LCSW
Susan Scott, LMFT
Lucy D. Solari, LMFT
James Archambeault, LADC
Rolando Martinez, LCSW
Mari Jo MacInis, LMFT
Jarel Gallman, LMSW

Today's Date________________________

*****PLEASE COMPLETE FRONT AND BACK OF FORM*****

PATIENT INFORMATION

Patient's Name: ____
First Name Middle Initial Last Name

Date of Birth: _______________ Marital Status: __________

Male: _______ Female: _______ Age: _____________ Email____

Patient's Address: ____
Street City State Zip

Home Phone: ____________________________ *Cell* Phone: ______________________________

Work Phone: ____________________________

Which number do you prefer calls:_________________ Which number /s OK to leave message:____________________________

How late in the evening will you receive calls? _________________

Referred to PATHWAYS by: ____

Name of Doctor / School:____

Have you ever been a patient at Pathways? _________________________________

If Patient is a Minor (Under 18 years of age):

Mother's Name: __________________________ Date of Birth: ________________ Age: _________

Address (If Different From Above): ____
Street City State Zip

Best contact phone #: ____________________________ Please circle: Home Cell Work

Father's Name: __________________________ Date of Birth: ________________ Age: _________

Address (If Different From Above): ____
Street City State Zip

Best contact phone #: ____________________________ Please circle: Home Cell Work

Thomas B. Allen II, Ph.D.
Suzanne D. Pascoe, LPC
Christie Hunnicutt, LCSW
Tracy A. Shiring, M.S. Ed
Tori Piraino, LCSW
Kelly Leach, LCSW
Lisa N. Backus, Ph.D.
Sarah A. Hallwood, LCSW
Christine Migdole, LCSW
Loren B. Sterman, LCSW
Susan Scott, LMFT
Lucy D. Solari, LMFT
James Archambeault, LADC
Rolando Martinez, LCSW
Mari Jo MacInis, LMFT
Jarel Gallman, LMSW

INSURANCE INFORMATION

Please complete all information accurately. Please have insurance card/s ready for required photocopy.

Insurance Company: ____

Policy #: _________________________ Group #: ___________________________

Person who carries the policy: ____
Name Date of Birth SS#

Employer Info: ____
Employer Name Relationship to patient

DO YOU HAVE SECONDARY INSURANCE? please complete section below:

Secondary Insurance Company: ____

Policy #: _________________________ Group #: ___________________________

Person who carries the policy: ____
Name Date of Birth SS#

Employer Info: ____
Employer Name Relationship to patient

EMERGENCY CONTACT INFORMATION:

NAME: _________________________________ RELATIONSHIP: _______________

ADDRESS: _________________________________

____

PHONE: (home) _______________ (cell) _______________ (work) _______________