PATHWAYS
Center for Learning & Behavioral Health, LLC

Thomas B. Allen II, Ph.D.
Suzanne D. Pascoe, LPC
Susan Scott, LMFT
Tori Piraino, LCSW
Jarel Gallman, LCSW
Christina Ignatiadis, LMSW
Judith Mohr, LMSW
Micaela Finnegan, LCSW
Christine Migdole, LCSW
Loren B. Sterman, LCSW
Tracy A. Shiring, M.S. Ed
Sarah A. Hallwood, LCSW
Rolando Martinez, LCSW
Margaret R. Watson, Psy.D.
Moheba Sayed, LPC
Mari Jo MacInnis, LMFT

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:_____

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):

Parent 1: _____ Date of Birth: _____ Age: _____

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

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

Parent 2: _____ _____ Date of Birth: _____ Age: _____

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

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

251 Westbrook Rd., Essex, CT 06426 Phone: 860-767-1277 FAX: 860-767-7712
314 Flanders Rd., Suite 2 B, East Lyme, CT 06333 FAX: 860-691-1546
2418 Boston Post Rd., Guilford, CT 06437 FAX: 203-689-5096
152 Broad St., Guilford, CT 06437
www.pathwaysct.com

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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)_____

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