DR. LAURA BOLOGH, Ph. D.
LICENSED CLINICAL PSYCHOLOGIST

Laura Bologh, Ph.D.
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Date___________
Patient's Name____
Home Phone_______________ Date of Birth ___________________
Cell Phone___________________ email address______________________
Street Address____
City________________________ State ____________ ZIP______________
Occupation______________________ Business Phone_________________

Spouse's Name ________________________ Age _______________
Cell Phone___________________ email address______________________
Street Address____
City________________________ State ____________ ZIP______________
Occupation_____________________ Business Phone___________________

Who is Responsible for this account ?_______________________________
Relationship to patient ______________________________________
Social Security # _________________Spouse's Social Security#___________

Insurance Information
Carrier____
____
Insurance I.D. # _______________________ phone# _____________________

Children:

Name	Date of Birth	Name	Date of Birth

Siblings:

Name	Date of Birth	Name	Date of Birth

Information regarding current medications (if applicable):

Name	Total Daily Dose	Approximate Start Date

Name and Address of Prescriber:

____

____

Name and Address of Primary Care Physician

____

____

Consent to the Release of records to my physicians:

____

Signature   Date

How did you learn of my practice? ________________________________

Whom may I thank for referring you?_____________________________

In case of Emergency , who should be notified ?_______________________

Phone_______________ relationship to patient_______________________

ASSIGNMENT AND RELEASE:
I understand that I am financially responsible for all the charges incurred in my treatment. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____

Signature of Responsible Party Date

____

Additional Signature (if appropriate) Date