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

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Date_____
Patient's Name_____
Home Phone_____ Date of Birth _____

Mother's Name _____ Age_____
Cell Phone_____ email address_____
Street Address_____
City_____ State _____ ZIP_____
Occupation_____ Business Phone_____

Father's Name _____ Age _____
Cell Phone_____ email address_____
Street Address_____
City_____ State _____ ZIP_____
Occupation_____ Business Phone_____

Responsible party (if a minor)_____
School Name_____
School Address _____
School Contact Person/People _____
School Phone_____

Who is Responsible for this account ?_____
Relationship to patient _____
Social Security # _____Spouse's Social Security#_____

Insurance Information
Carrier_____
_____
Insurance I.D. # _____ phone# _____

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 Pediatrician

_____

_____

Consent to the Release of records to my son / daughter's pediatrician:

_____

Signature of Guardian / Responsible Party 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 the treatment of my son/daughter. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____
signature of Guardian/Responsible party date

_____
additional signature (if appropriate) date

**please note that in cases where both parents / guardians do not reside in the same home BOTH signatures are required on the above release. Thank You.