PATHWAYS
Center for Learning & Behavioral Health, LLC

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

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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