Registration Form
Ellen H. Theodores, LCSW, LLC

Today's Date:	Primary Care Physician Name and Address:
/ /	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	
			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms

Birthdate:	Age:	Sex:	Marital Status (circle one)
		□ M □ F	Single / Married / Partnered / Divorced / Separated / Widowed

Street Address:	Home Phone	Work Phone:
	( )	( )

City	State	Zip Code	Cell Phone:
			( )

Occupation:	Employer Name and Address:	Employer Phone:
		( )

Referral Source (please check one box):				
❑ Dr._____	❑ Family/Friend_____	❑ Website	❑ Yellow Pages	❑ Other_____

INSURANCE INFORMATION

Person Responsible for Payment:	Birthdate:	Address (if different):	Home Phone
	/ /		( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	Please indicate primary insurance		
❑ Blue Cross	❑ Aetna	❑ Cigna	❑	❑	❑	❑

Subscriber's Name:	Subscriber's Social Security	Birth date:	Group #:	Policy #	Co-payment:
	- -	/ /			$

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	□ Other	
Name of secondary insurance (if applicable):	**Subscriber's Name**		**Group #**	**Policy #**	

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address):	Relationship to Patient:	Home phone:		Work Phone:
		( )		( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ellen H. Theodores, LCSW, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	*Date:*
Patient/Guardian Print Name:	