PAUL J. SCOGLIO, MSW, LICSW, CPCC

900 CUMMINGS CENTER, SUITE 417U, BEVERLY, MA 01915

978-921-8400 PAUL@PAULSCOGLIO.COM

REGISTRATION

Today's Date _____

Client's Name _____

Address _____
Street

_____
City State Zip Code

Client's Date of Birth _____-_____-_____
Month Day Year

Home Phone: ( ) _____

Work Phone: ( )_____Ext._____

Cell Phone: ( ) _____

EMAIL: _____@_____

Personal information:

Gender: Male_____ Female_____

Status: Married __ Single__ Sep.__ Div.__ Wid.__

Emergency Contact Person _____

Phone number_____

PAST/PRESENT MEDICAL CONCERNS Specify: major illnesses, accidents, hospitalizations and dates. **Use the back of this page if you need more room.**

_____

_____

Current Medication _____

_____

Who referred you? _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL PAYMENT OF SERVICES UNLESS OTHERWISE SPECIFIED.

Signature _____

Date of Signature _____

DX:

Primary Care Physician _____

City _____Phone _____

Last Medical Exam: Date _____

Are you covered by more than one health insurance plan? Yes ___ No ___ If yes, then please indicate that information on the back of this form.

Primary Insurance Company

Insurance Co. _____

Insurance **Phone #** _____

_____

Insurance **ID #** _____

Insurance **Group #** _____

Subscriber _____

Subscriber's Date of Birth _____

Address_____

Subscriber's Employer_____

Relationship of Client to Subscriber

Self_____ Spouse_____ Child_____ Other_____

If Harvard Pilgrim & UBH please provide the Subscribers Social Security # _____

Person responsible for the cost of services or the balance not covered by insurance:

___ Same as client named ___ Other

Name_____

Address _____

_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the provider of services to furnish information to insurance carriers concerning my condition and treatment and I hereby assign to the provider all payments for medical services rendered to myself or my dependents.

Signature _____

Date of Signature _____

Ins. Certification/Authorization # for services here: