



Center for Learning & Behavioral Health LLC

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Brian D. Fay, LCSW
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Cara E. Barbierrri, Psy.D.
Alison Thurber, LCSW
Lisa M. Tonnessen, Ph.D., LPC
Mari-Jo MacInnis, LMFT
Loren Sterman, LCSW
Ellen H. Pfarr, LCSW

Today's Date _____

PATIENT INFORMATION

Patient's Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Marital Status: _____

Male: _____ Female: _____ Age: _____

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: _____

How late in the evening will you receive calls? _____

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):

Mother's Name: _____ Date of Birth: _____ Age: _____

Address (If Different From Above): _____

Best contact phone #: _____ Street City State Zip
Please circle: Home Cell Work

Father's Name: _____ Date of Birth: _____ Age: _____

Address (If Different From Above): _____

Best contact phone #: _____ Street City State Zip
Please circle: Home Cell Work



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INSURANCE INFORMATION

Please complete all information accurately. Please have insurance card/s ready for required photocopy.

Insurance Company: _____

Policy #: _____ Group #: _____ Effective Date: _____

Person who carries the policy: _____
Name Date of Birth SS#

Employer Info: _____
Employer Name Relationship to patient

IS THERE A SECONDARY INSURANCE? please complete section below:

Secondary Insurance Company: _____

Policy #: _____ Group #: _____ Effective Date: _____

Person who carries the policy: _____
Name Date of Birth SS#

Employer Info: _____
Employer Name Relationship to patient

EMERGENCY CONTACT INFORMATION:

NAME: _____

ADDRESS: _____

PHONE: (home) _____ (cell) _____ (work) _____

Relationship to patient: _____