AARON POLSKY, LCSW
PATIENT REGISTRATION FORM- *MINOR*

(Please Print)

Today's Date:	Appt. With:	Whom may we thank for referring you?

PATIENT INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Sex: ❑ Male ❑ Female
Street Address	City	State	Zip Code	Home Phone No.:

PHONE NO. WE MAY LEAVE A MESSAGE ABOUT PATIENT?

MOTHER'S INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address and Work Phone				

FATHER'S INFORMATION

Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code	Cell Phone No.:
Employer's Name, Address, and Work Phone				

PRIMARY INSURANCE INFORMATION

Insured's Last Name, First Name, Middle Initial		Birth Date:	Social Security #
Insurance Company		Phone Number	
Insurance Billing Address:			
Policy No.:	Group no.:	Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent	

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insured's Last Name, First Name, Middle Initial		Birth Date:	Social Security #
Insurance Company		Phone Number	
Insurance Billing Address:			
Policy No.:	Group no.:	Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Aaron Polsky LCSW, Mary Englund, PsyD LLC, Dr. Kimberly A. Lemke, P.C, and those acting on the practice's behalf and the insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices & the Professional Service Agreement provided. I fully understand and accept the terms of this practice.

_____

Signature of Patient (age 12 & older) Date

_____

Guardian Signature Date