

**SAMANTHA MCGANN, 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: <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
<p>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 Samantha McGann, 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.</p>				
Signature of Patient (age 12 & older)			Date	
Guardian Signature			Date	

