Judith Margolin, Psy.D
NJ Licensed Psychologist #3493

Welcome to my office. Your cooperation in completing this form in detail will enable me to provide you with the most appropriate assistance.

Patient Information

Date: ___________

Name of Patient: ___________________________Age: ______ Date of Birth: ______________________________

Address: ____ Gender: ______________________

City: ____ State: _____________ Zip: ______________________

Marital Status: Married Single Other Employment: ____

Home Phone:________________________________ Mobile Phone: ____________________________________

Can we leave messages? Y/N Which phone is preferred? _________________________________

Email address: ____

Permission to contact PCP: Y / N Address: and Phone ____

Emergency Contact

Name: __________________________________ Relationship to Patient: _________________________________

Address: ____

City: ______________________________________State: _____________ Zip: ________________________________

Home Phone: ____________________________ Mobile Phone: ____

Consent to contact if necessary? Y / N

Insurance Information

Insured's Name: ____________________________Date of Birth: ______________ Gender: ___________________

Insurance Company: ________________________Ins. Co. Phone Number: _______________________________

Insurance Company Address: ____

Patient's Relationship to Insured: (Please circle one) Self / Spouse / Child / Other

Insured's Employer: _________________Insured's ID #: ____________Group or Policy : ____________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.	I authorize payment of medical benefits to the undersigned physician or supplier for services.
Signed________________________________ Date_________	Signed____________________

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