Dawn M. Roy, LCSW
Therapist **203-331-7458**
540 Tunxis Hill Road
Fairfield, CT 06825

Client Name:_____ Client D.O.B._____

Client Address:_____ Occupation:_____

_____ Employer/School:_____

Home Phone:_____ Marital Status:_____

Work Phone:_____ Spouse's Name:_____

Cell Phone:_____ Children's names and DOB:_____

Health Insurance:_____ _____

Client SSN: _____ Please read and sign the following only if using Insurance: I authorize Dawn M. Roy, LCSW to release to the above insurance company all needed clinical information requested by the above insurance company with respect to any treatment received by me or my children.

Insured SSN:_____

If client is a minor, parent/guardian: Client signature:_____

Home Phone: _____ Parent / Guardian _____

Work Phone:_____ Cell Phone: _____

Address if different than client:_____

Insurance phone numbers (member services and provider services)_____

Referral source (who referred you to me?)_____

If applicable: Current psychiatrist name and phone number:_____

Current medication and dosage:_____

Other professionals involved: (lawyers, doctors, therapists, school personnel, probation officers): _____
_____

Please name two people who may be contacted in the case of an emergency:

1) Name/relationship/phone: _____ 2) Name/relationship/phone: _____