



Intake Form

Demographic Information

First Name:	_____
Middle Initial:	_____
Last Name:	_____
Date of Birth:	_____
Social Security Number (Optional):	_____
Sex:	M F
Marital Status:	_____
Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Phone Number:	_____
Email Address:	_____

Referring Physician Name (Optional):	_____

Referring Physician Phone Number & NPI (Optional) :	_____

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____
Guardian Signature (if minor): _____ Date: _____
Patient Full Name: _____



Lauren Rothstein, LCSW, P.A.
Licensed Psychotherapist

Credit Card On File

Credit Card Full Name: _____

Credit Card Number: _____

Expiration Date: _____ / _____ Security Code (3 Digits for Visa, 4 Digits for AMEX): _____