

Carolyn Sharp, LICSW
 2021 Minor Avenue east #3
 seattle wa 98102
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Patient Name: Last	First	MI	Sex	Marital Status	Birthdate	Referred By
Address			City		State	Zip
Patient's Employer		Occupation		Soc. Sec #		Work Phone

Responsible Party #1	Birthdate	Soc Sec #	Relationship	Marital Status
Address (if different from Patient)		City		State
				Zip
Home Phone		Employer		Occupation
		Work Phone		Cell Phone

NOTE: If parents are divorced and medical decision-making is shared, both parents must agree to the evaluation.

Responsible Party #2	Birthdate	Soc Sec #	Relationship	Marital Status
Address (If different from Resp. #1)		City		State
				Zip
Home Phone		Employer		Occupation
		Work Phone		Cell Phone

Emergency Contact				Relationship
Address		City		State
				Zip
Home Phone				

Insured's Name	Relationship	Soc Sec #	Birthdate
Primary Insurance Company		Group #	
		Policy #	
Insurance Company Address		City	
		State	
		Zip	
Phone			

I hereby acknowledge and accept financial responsibility for charges incurred by the above named patient while under the care of _____.

SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the undersigned physician to provide information gained through history, physical, progress notes, EKG and lab findings may become necessary to aid in processing any future insurance claims.

SIGNATURE _____ DATE _____