Dr. Beth Giurelli, Psy.D. LLC
Licensed Psychologist
131 Oak Street
Glastonbury, CT 06033

Patient Information

The information on this form is confidential to the extent provided by law, and is not made available to anyone else without your explicit written permission. The confidentiality of this information is protected by state and federal law and professional ethics, and is subject to the limits of confidentiality as described in the Psychotherapist-Client Services Agreement.

Date:_____ Date of Birth:_____

Name:_____

Street Address: _____Town: _____ State: ____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Okay to leave messages?_____

Spouse/Partner Name:_____

Home Phone:_____ Work or Cell Phone:_____

How did you hear about Dr. Giurelli's practice?

____Referred by:_____

____ Other:_____

In case of emergency, please contact:

Name: _____ Relationship:_____

Street Address: _____Town: _____Zip:_____

Phone: _____

Name, age and gender of children, if any:

Name and phone number of Primary Care Physician:

Name of Psychiatrist (if applicable):

Name of Insured: _____ Relationship:_____

Street Address: _____Town: _____Zip:_____

Phone: _____ Date of Birth: _____

Name of Employer: _____

Please list any medical conditions, allergies, or hospitalizations:

Please list any current medications you are taking: (continue on back if needed)

Name of medication	**Dosage / Frequency**	**Date you began taking it**	**Prescribing physician**

Is there any other information you wish Dr. Giurelli to be aware of? (continue on back if needed).

I understand that I am financially responsible for all charges associated with services provided by Beth Giurelli, Psy.D.to me or my dependents. I understand that I am responsible for contacting my insurance regarding the terms of my benefits and if my insurance requires a referral, preauthorization, or other condition for treatment, I am responsible for meeting those requirements. I authorize the release of any information necessary to process insurance claims and I authorize payment of insurance benefits directly to Beth Giurelli, Psy.D. **I also understand the 24 Hour Cancellation Policy which requires that I cancel my appointment 24 hours in advance to avoid being charged for the session**.

Signed_____ Date_____