Registration Data
Carole Stokes-Brewer, PhD, LISW, LICDC

Name____
(Last) (First) (Middle Initial)

Home Address_____________________________City_____________________State_____Zip__________

Home Phone: ( ) ________ - ________ May we leave a msg? Yes ___No ___

Work Phone: ( ) ________ - ________ May we leave a msg? Yes ___No ___
Cell: ( ) ________ - ________ May we leave a msg? Yes ___No ___
E-mail: ____ May we email you? Yes ___No ___

Marital Status (circle one) M S W D Sep. Date of Birth__________

Occupation____Employer_______________________________

Name of person responsible for your account____

Their Date of Birth_______________Their Address____

Their Employer____

Is there other medical insurance? Yes ___No___ Is this a work related injury? Yes___ No___

In whose name is the insurance policy?

Insurance Company #1 ____

Insurance Company #2 ____

Who referred____

# of children ______ # of children at home _______

Have you had previous psychotherapy? Yes ___ No ___ Previous therapist's name_________________________

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes ___ No ___

If Yes, please list: ____

If no, have you been previously prescribed psychiatric medication? Yes___ No ___

If Yes, please list: ____

RELEASE & AGREEMENT

1. **I understand that I am financially responsible for ALL charges whether or not covered by my insurance policy.**

2. **I authorize and request payment of medical benefits directly to: Carole Stokes-Brewer**

3. **I authorize release of any medical information necessary to process my insurance claim(s).**

____ ________/____/_______
Patient signature **Date of signature**