DAWN DUIGNAN, LCSW-C
3881 TEN OAKS ROAD, 2A
GLENELG, MD 21737
(410) 489-4550

PATIENT INFORMATION

Patient's Name:			Marital Status (circle one) ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
If Minor, Parents Name:		Custody restrictions: ☐Yes ☐No Please Explain:	Birth Date (mm/dd/yy)	Sex: ☐ M ☐ F
Home Address: City, State, Zip:			Home Phone: Cell Phone:	
Occupation or Student:	Employer or School:		PCP:	

INSURANCE INFORMATION

(Please provide a copy of your card)

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber's Name:	Birth Date: (mm/dd/yy)	Insurance Plan:	Policy #:	Group #:	Co-payment: $

Patient's relationship to subscriber: ☐Self ☐ Spouse ☐Child ☐ Other

Is there secondary insurance? ☐Yes ☐No Name of secondary Insurance: (If applicable)	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: ☐Self ☐ Spouse ☐ Child ☐Other

BACKGROUND AND REFERRAL INFORMATION

Referred to Clinic by (please check one):

☐ Dr. ☐ Insurance ☐ Friend ☐ Family ☐ Other (please specify)

Reason for Referral:

Medication and any current medical problems:

Previous mental health treatment and/or diagnosis:

Goals for treatment:

AUTHORIZATION

- The above information is true to the best of my knowledge.
- I authorize my insurance benefits be paid directly to the therapist.
- I understand that I am financially responsible for any balance and co-pay at time of visit.
- I authorize Dawn Duignan, LCSW-C or my insurance company to release any information required to process my claims.
- I will be responsible for the full payment of a scheduled session if I do not give 24 hours notice of cancellation.

☐ I have received a copy of the HIPPA form. (**Please check**)

Patient/Guardian signature *Date*