

**JUDITH MARGOLIN, PSY.D.**  
NJ Licensed Psychologist # SI00349300

601 Ewing St. C20A  
Princeton, NJ 08540

Tel: (609) 658-2536  
Fax: (732) 329-1634

Welcome to my office. Your cooperation in completing this form in detail will enable me to provide you with the most appropriate assistance.

---

**PATIENT INFORMATION**

Date: \_\_\_\_\_  
Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital Status: Married Single Other    Employment: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
Can we leave messages? Which phone is preferred? \_\_\_\_\_  
Email address: \_\_\_\_\_  
Permission to contact PCP: Y / N    Address: and Phone \_\_\_\_\_

---

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
Consent to contact if necessary? Y / N

---

**INSURANCE INFORMATION**

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Ins. Co. Phone Number: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Patient's Relationship to Insured: (Please circle one) Self / Spouse / Child / Other  
Insured's Employer: \_\_\_\_\_  
Insured's ID #: \_\_\_\_\_ Group or Policy #: \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.	I authorize payment of medical benefits to the undersigned physician or supplier for services.
Signed _____ Date _____	Signed _____

