Emanuel Troiani, Psy.D.

Licensed Clinical Psychologist, Neuropsychologist
Certified School Psychologist

1018 N. Bethlehem Pike, Suite A-1
Lower Gwynedd, PA 19002

700 Horizon Circle, Suite 101
Chalfont, PA 18914
(215) 233-5688

Updated 1/22

****PLEASE FILL OUT THIS FORM COMPLETELY****

Patient Information

Patient First Name: ________________________ Middle Initial ____ Last Name ____________________________

Preferred Pronoun: ______________________, Date of Birth: _______________, SS# ______-______-________

Address: ____
(Street Address)

____, ***email:** ____________________________________
(City, State, Zip)

Phone #: (H)______________________ (C)_______________________ Is it okay to leave a message? ***(Y / N)***

Emergency Contact: ___________________________________ Contact phone # __________________________

Name of person(s) with whom we may discuss your treatment: ____

Insurance Information

Employer: ____

Primary Insurance ______________________________ ***Member ID #*** ___________________________________

Is this a group plan ***(Y / N)***? Group # ______________________, Is this an employer-sponsored plan ***(Y / N)***?

Relationship to Policy Holder: (self/spouse/child/other) Policy Holder's Employer ______________________

Policy Holder's Name: _____________________________, Policy Holder's Date of Birth: _____________

Secondary Insurance ____________________________ ***Member ID #*** ___________________________________

Is this a group plan ***(Y / N)***? Group # ______________________, Is this an employer-sponsored plan ***(Y / N)***?

Relationship to Policy Holder: (self/spouse/child/other) Policy Holder's Employer ______________________

Policy Holder's Name: _____________________________, Policy Holder's Date of Birth: _____________

Physician Contact Information

Primary Physician ______________________________ Phone # ________________ Fax # _________________

Referring Physician ____________________________ Phone # ________________ Fax # _________________

****I authorize Emanuel Troiani, Psy.D. to obtain/release information from/to the above named physician(s).****

Patient Signature (if minor, write "minor") ____ **Date** ____________

Parent/Guardian Signature #1 (for minor patient) _____________________________________ **Date** ____________

FOR PATIENTS UNDER 14 YEARS OF AGE (Required):
Per PA State Law, we must obtain the signatures of both Parents/Legal Guardians to administer testing to children under 14 years of age. If second parent is deceased, check this box: ☐

Parent/Guardian Signature #2 (for minor patient) _____________________________________ **Date** ____________

© 2020 Emanuel E. Troiani, Inc.