Dina M. Lomas, LCSW
1728 Jonathan Street, Suite 204
Allentown, PA 18104
610-698-2852
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General Information and Consent to Treatment

Name: _____

Date of Birth: _____/ _____/ _____

Address: _____
Street Name and Number

_____
City State Zip Code

Phone: Home _____ Work _____

Cell _____

Email Address: _____

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Insurance Information:

Name: _____

ID#: _____ Group#: _____

Phone: _____

Address: _____

If Child or Adolescent (Parent/ Legal Guardian Information):

Parent /Guardian 1 Name: _____ Phone: _____

Parent/Guardian 1 Address: _____

Parent /Guardian 2 Name: _____ Phone: _____

Parent/Guardian 2 Address: _____

I give my consent to treatment/therapy by Dina M Lomas, LCSW.

Signature Date

Parent/ GuardianSignature Date

Witness Signature Date