Psychiatric Health Professionals, P.C.
709 Canton Rd., Suite 200, Marietta, GA 30060
770-426-3088

PATIENT INFORMATION

Date_____
Last Name_____First_____Middle_____
Address _____
City/State/Zip_____Soc. Sec.#_____
Marital Status: S M D W Sex: M F Date of Birth_____/_____/_____ Age _____
Home Phone_____Cell Phone_____
Employer_____Work Phone_____
Employer address_____

SPOUSE/GUARDIAN

Spouse/Guardian_____Date of Birth_____/_____/_____
Employer Name_____Soc Sec.#_____
Address (if different)_____
Home Phone_____Work Phone_____Cell Phone_____

EMERGENCY CONTACT

Name_____Relationship_____
Address_____Phone_____

INSURED OR RESPONSIBLE PARTY

Name_____Relationship_____
Address_____
Soc. Sec.#_____Date of Birth_____/____/_____
Employer_____Work Phone_____

INSURANCE INFORMATION

Name of Insurance Company_____
Insurance Claims address_____
Policy Number_____
Group Number_____Effective Date_____
Policyholder's Name_____Relationship_____
Policyholder Date of Birth ____/_____/_____ Policy Holder Soc.Sec.#_____

I hereby assign medical benefits to which I am entitled to this office, unless revoked by me in writing . I authorize any information needed to be released to my insurance company for the purpose of authorizing and processing my claims. I understand that I am fully responsible for, and will assume all my charges not paid by my insurance. **I UNDERSTAND THAT I WILL BE CHARGED IN FULL FOR ANY APPOINTMENTS NOT KEPT UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE**.

Signature of Patient/Guardian_____Date_____