

**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 \_\_\_\_\_