

Psychiatric Health Professionals, P.C.
598 Nancy St, Suite 150, Marietta, GA 30060
770-426-3088

PATIENT INFORMATION

Date _____

First Name _____ Last _____ M.I. _____

Address _____

City/State/Zip _____ Soc. Sec.# _____

Marital Status: S M D W Sex: M F Date of Birth ____/____/____ Age _____

Primary Phone _____ Secondary Phone _____

Employer _____ Other 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 (POLICY HOLDER) INSURANCE INFORMATION

Policy Holder Name _____ Relationship to Patient _____

Name of Insurance Company _____

Member ID _____ Group Number _____ Effective Date _____

Soc. Sec.# _____ Date of Birth ____/____/____

Employer _____ Work Phone _____

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 _____

Updated _____ Date _____