Psychiatric Health Professionals, P.C.
709 Canton Rd., Suite 200, 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_____Email Address_____
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_____