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Roswell, GA 30075
678.867.7020

Patient Information

Name: ____ Date: ___________
Last First Middle

Address: ____

City: _________________________________ Zip: ________________________

Home Phone: ( )__________________ Work Phone: ( )_________________

Is it OK to leave a message at your work number? Yes / No

Confidential Email Address: ____

Social Security Number: _____________________________ Sex: ____________

Occupation: ___________________ Age: ______ Date of Birth: _________________

Name of Parent (If patient is under age 18): ______________________________________

Custodial Parent: Yes / No

Marital Status: ___________________ Spouse's Name: _____________________

Do you have any children? Yes / No If yes, names and ages: ___________________

____

Referred By: _________________________ Phone: _______________________________

ARE YOU CURRENTLY RECEIVING MEDICAL OR PSYCHOLOGICAL TREATMENT?
YES / NO

IF YES, FROM WHOM: ______________________________ Phone: _______________

Current Medications: ____

Emergency Contact: ___________________________ Relationship: __________

Phone number of emergency contact: _____________________

INSURANCE INFORMATION

Insurance Company Name: ____

Address: ____

City: ______________________________ State: _____ Zip: __________________

Phone: _____________________________ Contact Person: _____________________

Group Number: ______________________ Policy Number: _____________________

Treatment Authorization Number: ___________________________

Is the insured different from the patient: YES / NO

If yes, Name of the insured: ____

Patient's relationship to the insured: Child / Spouse / Other

Date of Birth of Insured: ___________________

Social Security number of insured: __________________________