

# Atlanta Behavioral Care

Please check your status:  New patient  Hospital Follow-up visit  Other: \_\_\_\_\_  
 Suboxone Ambulatory Detoxification  Prometa treatment

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(last) (first) (mi)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work : \_\_\_\_\_ Other: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Male/Female \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency #: \_\_\_\_\_

Relationship: \_\_\_\_\_ Does patient have a legal guardian?  yes  no

Name of Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

Name of insured person (policy holder): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work : \_\_\_\_\_ Other: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to patient:  self  mother  father  other \_\_\_\_\_

Do you have a secondary insurance policy?  yes  no If yes, please complete the following:

Name of insured person (policy holder): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Work : \_\_\_\_\_ Other: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Relationship to patient:  self  mother  father  other \_\_\_\_\_

Did you contact insurance company to authorize today's visit?  yes  no  not required

**Who referred you to Atlanta Behavioral Care?**

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**Please provide a PHOTO ID and a copy of your insurance card to the office staff.  
Without proof of insurance, we require payment in full at the time of your visit.**

**Please provide a "last minute" telephone number where you can be reached in case the doctor has an emergency and your appointment has to be rescheduled: \_\_\_\_\_**

*Thank You.*