Atlanta Psychiatry & Neurology d/b/a Atlanta Behavioral Care

Today's Date: _____/_____/_____ Who Are You Here To See Today? _____

Patient Registration

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____/_____ /_____ Social Security #:_____ /_____ /_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separate

Address: _____ City: _____St: _____ Zip: _____

Does Pt. Reside in a Group / Residential Home ☐ Yes ☐ No If yes, Name: _____

1) Home Phone # (_____) _____ 2) Mobile Phone: # (_____) _____

How do you prefer to be contacted for Appointment Confirmations?

☐ Phone Call or ☐ Text Msg, or ☐ Personal Email @_____

If by telephone, which number to use from above? ☐ #1 ☐ #2

Emergency Contact Name: _____ Relationship to Patient: _____

Legal Guardians' Name: _____ Phone # (_____) _____

Insurance Information

☐ Copy of Cards Obtained

Primary Insurance Co.: _____ID #:_____

Name of Policy Holder: ☐ Self / Other: _____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other _____

DOB: _____/_____/_____ Social Security #:_____ /_____ /_____

If different than patients, Please provide Phone Number: (_____) _____

Secondary Ins Co.: _____ID #:_____

Name of Policy Holder: ☐ Self / Other: _____

Tertiary Ins Co.: _____ ID #:_____

Person Accompanying This Patient Today: _____

Person Completing This Form if Other Than Pt.: _____

_____

Signature of Patient or Guardian

Office Use Only:

Staff Member Registering this Patient:_____