Atlanta Psychiatric Specialists, PC

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REGISTRATION FORM

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Married or Domestic Partner / Divorced / Widowed

Preferred Name:	Maiden Name (if applicable)	Social Security Number	Birth Date / /	Age	Gender

Home Phone No. ( )	Cell Phone No. ( )	Email Address

Home address	Apt #	City	State	ZIP Code

Employer	Occupation	

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ APS Website ❑ Other

Other Family Members Seen Here

IN CASE OF EMERGENCY

Emergency Contact Name	Relationship to Patient	Phone Number

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ Cigna ❑ PHCS ❑ United Healthcare ❑ Other: __________________________

Member ID or Policy #____________________________________ Group or Account #____________________________________

Your signature below acknowledges your understanding and acceptance of the following information:

Insurance benefits for which our office maintains a contractual agreement will be paid directly to the office. You are responsible for any charges not covered by your insurance that are not excluded by a contractual arrangement.

If applicable, Atlanta Psychiatric Specialists, P.C. may release limited personal health information to your insurance company as necessary to process a claim for treatment. This information may include personal health information related to mental health and substance abuse treatment and will be subject to all federal and state regulations. For more information on your rights and responsibilities regarding your personal health information maintained at this office, please review our **Notice of Privacy Practices**.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Adopted: 10/2011