Atlanta Psychiatric Specialists, P.C.

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Dr. Ross F. Grumet

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid / Domestic Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Gender

Driver's License #, State	Cell #	Social Security	Home Phone No. ( )

Home address: Street Address	Apt #	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

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

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

Other Family Members Seen Here ____________

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

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ UHC ❑ State Health ❑ Cigna ❑ PHCS

❑ Aetna ❑ Medicare ❑ Medicaid ❑ Other ____________

Subscriber's Name	Subscriber's SSN	Birth Date / /	ID or Policy #	Group or Account #	

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Psychiatric Specialists, P.C. or insurance company to release any information required to process my claims. I hereby give my consent for treatment by Dr. Ross F. Grumet. I have been given the opportunity to review the privacy practices of Atlanta Psychiatric Specialists, P.C. as required by HIPAA laws.

X ____

PATIENT/GUARDIAN SIGNATURE DATE