NORTHWEST BEHAVIORAL MEDICINE

PATIENT IDENTIFICATION

Last Name _____ First _____ Middle _____

Home Address _____ Apt. _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Date of Birth _____ Social Security Number _____

EMPLOYMENT

Employer _____ Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone Number _____ Address _____

FINANCIAL RESPONSIBILITY

Last Name _____ First _____

Address _____ City _____ State _____

Zip _____ Home Phone _____ Business Phone _____

INSURANCE- PLEASE PRESENT YOUR INSURANCE CARD TO OUR RECEPTIONIST.

Name of Insurance Company _____

Claims Address _____

Group Number _____ Policy Number _____

Effective Date _____ Policy Holder's Name _____ Relationship to patient _____

Policy Holder's Social Security Number _____ Policy Holder Date of Birth _____

ADDITIONAL CONTACT INFORMATION

Fax _____ Cell Phone _____ Pager _____

Home Email _____ Work Email _____

IF YOU HAVE INSURANCE THAT REQUIRES PREAUTHORIZATION, YOU MUST NOTIFY THE FRONT OFFICE BEFORE EACH VISIT. IT IS YOUR RESPONSIBIILTY TO ENSURE THAT YOUR VISITS ARE AUTHORIZED SO THAT THEY MAY BE COVERED BY YOUR INSURANCE.

I hereby authorize any information needed to be released to my insurance company for the sole purpose of authorizing and processing my claims. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. **I understand that I will be charged in full for any appointments not kept unless 24 hours notice is given to the office.** I consent for treatment necessary for the care above named patient. I have read, understand and agree to the office policies attached.

_____ _____

Signature of Patient of Guardian Date

108 Margaret Avenue • Marietta, GA 30060 • (770) 422-2009
11755 Pointe Place, Suite A-1, Roswell, Ga. 30076 • (770) 667-1264

LAST NAME_____ FIRST_____ MIDDLE_____

Briefly describe the reason for your visit:

_____

_____

_____

_____

_____

_____

_____

_____

Please list the Doctor and /or Therapist who your are currently receiving treatment:

_____

_____

_____

Practice Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Office Telephone:_____ Fax _____

Have you ever been hospitalized in the past for any psychiatric difficulties? Please list the dates and places of hospitalization:

_____

_____

_____

Please list all medications that you are currently taking:

_____

_____

_____

I hereby authorize verbal/written (circle one or both) information to be released to:

_____

_____

Signature: _____ Date_____

Patient or Patient's Guardian