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	Sex ❑ M ❑ F

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)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

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 #	Co-Payment $

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