NAP

North Atlanta Psychiatry

New Patient Registration

Date: _____ Account# (Office Use) _____

PATIENT INFORMATION		
Last Name:	First Name:	MI:
Preferred Name:		
Address:		
City/State/Zip:		
Phone numbers (please check the preferred number) ☐ Cell _____ OK to leave message? ☐ Yes ☐ No ☐ Home _____ OK to leave message? ☐ Yes ☐ No ☐ Work _____ OK to leave message? ☐ Yes ☐ No		
e-mail Address:		Gender : ☐ Male ☐Female
Date of Birth:	Age:	SS#
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Race: ☐ Caucasian ☐ African-American ☐ Native-American ☐ Hispanic ☐ Asian ☐ Other		
Employment: ☐ Employed Full-time ☐ Employed Part-time ☐Run Household	Student : ☐ Full-time Student ☐Part-time student	

Employment Information	
Employer	Occupation:
Employer Address:	
City/State/Zip:	

EMERGENCY NOTIFICATION	
1. Name:	
Relationship to patient:	Phone:
2. Name:	
Relationship to patient:	Phone:

Initial_____ Date:_____

3582 Old Milton Parkway, Alpharetta GA 30005
770-225-3000 Fax: 770-225-3001
www.drmattam.com

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PRIMARY INSURANCE INFORMATION	
Insurance company:	
ID#	Effective date:
Policy Holder Name:	Group #:
Policy Holder Date of Birth:	Policy Holder's SSN:
Relationship to patient:	Claims Address:
Have you contact Insurance for an authorization? ☐ Yes ☐No Auth# _____ Phone number for Authorization if different from Insurance phone#:	

SECONDARY INSURANCE INFORMATION	
Insurance company:	
ID#	Effective date:
Policy Holder Name:	Group #:
Policy Holder Date of Birth:	Policy Holder's SSN:
Relationship to patient:	Claims Address:
Have you contact Insurance for an authorization? ☐ Yes ☐No Auth# _____	

FINANCIALLY RESPONSIBLE PARTY		
Last Name:	First Name:	MI:
Address:		
City/State/Zip:		
Home Phone: Work Phone: Cell Phone:		
Employer:	Relationship to patient:	

Initial_____ Date:_____

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PRIMARY CARE PHYSICIAN	
Name:	
Address:	
City/State/Zip:	
Phone:	Fax:

REFERRAL SOURCE
How did you hear about this office?

ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT

IF YOU HAVE INSURANCE THAT REQUIRES PRE-AUTHORIZATION, YOU MUST NOTIFY THE FRONT OFFICE BEFORE EACH VISIT. IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOUR VISITS ARE AUTHORIZED SO THAT THEY MAY BE COVERED BY 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 $40 for any appointment not kept unless 24 hours notice is given to the office.** I consent for treatment necessary for the care of above named patient. I have read, understand and agree to the office policies provided to me.

_____ _____

Patient Name (Print) *Legal Guardian Name (Print)*

_____ _____

Signature of Responsible Party *Date*