Psychiatric Professionals of GEORGIA

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Your Journey to Wellness

New Patient Form

Patient Demographics:

Name (First, MI, Last):_____ Birthdate: _____ Gender: __

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone (main): _____ Alt Phone: _____

Primary Email: _____

Guarantors Demographics (Legal Guardian if minor, who is primary on insurance):

Name (First, MI, Last):_____ Birthdate: _____ Gender: __

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone (main): _____ Alt Phone: _____

Insurance (Primary):

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID #:_____ Group #:_____

Subscriber (Primary on Insurance):_____ Relationship: _____

Insurance (Secondary):

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID #:_____ Group #:_____

Subscriber (Primary on Insurance):_____ Relationship: _____

SIGNATURE ACKNOWLEDGEMENT

Your signature acts as a comprehensive signature acknowledgement for the following forms and policies. These forms have been sent to you through patient portal, are available on the website, and can be printed for you at your request. You further acknowledge that you have read, understand, and accept each policy in its entirety.

HIPPA Form ◆ Controlled Substance Agreement ◆ Payment Policy ◆ Treatment Consent

Signature: _____ Date: _____

Print Name: _____

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Visit Information

Reason for visit: _____

Family members at home (Spouse, Parents, children, siblings, and other relative), include relationship to the patient.

1. _____ 2._____
3. _____ 4. _____
5. _____ 6. _____

Primary Care or Referring Doctor: _____

Current Medical Illnesses: _____

Medication Allergies: _____

List all **current** medications including dosage and frequency it is taken:

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all **prior** Psychiatric Medications including maximum dosages and frequency:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Current Pharmacy: _____

Prior Psychiatric History (Inpatient admission, Prior Providers, Prior diagnosis, Psychological Testing, etc..)

_____
_____
_____
_____

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