Patient Registration Information

Patient Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone Numbers: Home (___) _____ Cell (___) _____

Date of Birth: _____ Age: _____ Gender: Male ____ Female ____

Martial Status: _____

Employer: _____ Position: _____

Referred by? _____ Relationship: _____

May we thank this person for referring you? Yes _____ No ____

Insurance Information

Insurance Name and Address	
Policy ID number	
Policy Group Number	
Insurance Phone Number	
Mental Health Phone Number	
Policy Holder Name	
Policy holder DOB	

For patients under 18 years old please fill out the below information:

Mother's Name: _____ Cell:_____ Day: _____ Eve: _____

Father's Name: _____ Cell:_____ Day: _____ Eve: _____

Responsible Party: Self ____ Parent ____ Other ____

Name: _____ Social Sec Number: _____ Date of Birth: _____

Address (if different from above): _____

Employer: _____ Employer Address: _____

School/Grade _____

Medical History

Pediatrician or Family Physician: _____ Phone: _____
Address: _____

Date of last physical: _____ Please list any medical conditions you have or have had in the past: _____

Please list any prescription or non-prescription medications you are currently taking: _____
_____

Have you ever been hospitalized for medical or emotional reasons? Yes ____ No ____ If yes, please state reason and dates of hospitalization. _____
_____

Anxiety	Depression	Fears	Separation/divorce	Relationships
Anger	Sleep	Substance abuse	Alcohol	Autisim
Concentration	Legal issues	Pain management	Eating/food issues	School/educational
Losses	Spirituality	Loneliness	Energy level	ADHD
Sexual Concerns	Sexuality	Too emotional	Family/friends	Suicidal thoughts
Sexual Abuse	Physical Abuse	Trauma	Communication	Self harming

Circle any of the following concerns that pertain to you.

Other Issues you would like to include:

Other family members that maybe included in therapy sessions, names and birthdates:

A treatment plan will be developed based on your assessments and goals you and your family are committed to achieving. Please identify specific issues and goals you would like to address while in therapy.
_____
_____
_____
_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(Responsible party)

Laura Graham, LPC
3855 Shallowford Road Suite 420
Marietta, GA 30062
770-592-0566

Authorization to release information to insurance company for payment.

Client Name: _____

Birth Date: _____ Social Security Number: _____

I, REQUEST AND AUTHORIZE, Laura Graham TO:

1. Release and Request information to my insurance company.
2. Seek Payment from my mental health benefits.

(INSURANCE COMPANY) _____

(ADDRESS) _____

(CITY/STATE/ZIP) _____

(PHONE) _____ (FAX) _____

Please Note: Benefit verification is not a guarantee of payment by your insurance company.

Information released may include mental health privileged or confidential information, alcohol, drug or other treatment information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After considering the above statement, I authorize Laura Graham to furnish information regarding my treatment to the above insurance company. I also agree to hold harmless Laura Graham from all liability that may arise from the release of information requested.

I understand that this authorization may be revoked by me at any time, except when information released in accordance with state or federal law.

_____ _____
Date Signed Client Signature

_____
Parent Signature/ Legal Guardian