Atlanta Psychological Services, LLC

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Rev 10-11-17

Client Information

Please Print Clearly:

Date ________________

Who referred you to our office? ____

Client's Name: Last __________________________________ First________________________ M.I. __

Client's Date of Birth:________________________________Sex: M __________ F_________

Client's SSN:________-_______-_________ Check one: Single _____ Married _____ Divorced _____ Partnered ______

Street Address (No P.O. Boxes) ____

City _____________________________________ State _______Zip ___________

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If client is a minor, provide name & relationship of guardian/responsible party:

Guardian's Name: Last______________________________First___________________________M.I.___

Relationship to Client: __________________________________

Who filled out this form? ____

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Primary Insurance Carrier: ________________________________ Policy / Group #: ___________________

Insured's Name: ____ Insured's Birthdate: ________________

Insured's ID/SSN:_____-______-______________________Insured's Employer: _______________________

Secondary Insurance Carrier ____________________________ Policy / Group #______________________

Insured's Name: ____________________ Insured's Birthdate:______________________________________

Primary Care Physician (PCP) or Pediatrician's name: ____

PCP Phone number:______________________Fax number: _________________________

PCP Address: ____