



2308 Perimeter Park Drive Suite 100 Atlanta, GA 30341
AtlantaPsychological.com

770.457.5577 770.457.5599

Client Information

Rev 1-7-20

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: _____