Dunwoody Psychiatry & Psychotherapy Center (DPPC)

Demographic Information

Patient Information (Please Print):

First Name: ____________________ Middle Initial: ___ Last Name: __________________________

Date of Birth: ___________________________

Cell Phone Number: _______________________

Home Phone Number: ______________________

*Social SS #: ________-_________-___________

Billing Address: ___________________________

____

Emergency Contact: _____________________

Relationship: ___________________________

Phone Number: _________________________

Email Address: ____

I authorize confidential messages to be left on home/cell phone. (circle one) Signature ______________

Reason for your visit today: ____

Employment Information:

Employment Status (circle): Employed Unemployed Other: ________________________

Occupation:____

Employer Name: ____

Work Phone Number: ____

Insurance Information:

Primary Insurance: ____

Member ID/Policy # __________________________ Group # _________________________________

Patient is Subscriber/Policy Holder please circle **Yes or No**

Secondary Insurance: ____

Patient is Subscriber/Policy Holder please circle **Yes or No**

Insured Information (If Other Than Patient):

Policy Holder: ____________________ Relationship to patient: ___________ Phone #: ____________