Client information

North Atlanta Psychiatric Services, Inc.
Joseph Berger, MD, RPh

Please print and fill out this form completely:

Today's date: _____

Client name: _____
(first) (last) (middle)

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: (___)_____ work/other phone: (___)_____

Cell: (___)_____ E-mail: ___ _____

Client Social Security #: _____-____-_____ Date of Birth: _____/_____/_____

Sex: Male / Female Marital status: _____

Is the client under Age 18: Yes / No

If Yes, Name of Parent or Parents/Legal Guardian Bringing Child To Appointment:

_____

_____

PCP Name:_____ PCP phone: (___)_____ PCP fax: (___)_____

Optional Information:

Employer / School: _____

_____

Though I do not take insurance at this time it may be useful to know some basic information. Especially if you plan to fill my prescriptions though your coverage. Certain carriers have different formulary restrictions

Insurance co.(name and address): _____

Policyholder's name: _____ Date of Birth: ___/___/_____

Policyholder's social security #: _____-____-_____ Member ID Number#: _____

Phone # for mental health benefits/services:_____

Is the Plan an: HMO POS PPO

Referred by: (please circle) Insurance Phone Book Internet PCP/ Another MD Friend/Family

May I contact your referral source to thank them for referring you to my practice?

If yes: whom shall I contact? _____

EMERGENCY CONTACT INFORMATION

North Atlanta Psychiatric Services, Inc.
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Emergency Contact: _____ Relationship: _____
Street Address: _____
City: _____ State: _____ Zip: _____ Sex: Male / Female
Home Phone: _____ Work Phone: _____
Pager: _____ Cell Phone: _____

Spouse/Partner (If Not Emergency Contact): _____

Home Phone: _____ Work Phone: _____

Pager: _____ Cell Phone: _____

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Contact Information

* May I contact or leave messages for the client or parent/legal guardian at home number listed?

Please Circle: **Yes** Or **No**

Notice To Clients

Joseph Berger MD cannot release information of any kind, including information about appointments or billing to anyone other than the client or parent / legal guardian of the client.

_____ _____
Signature of Client or Legal Guardian Date