Empower Psychiatry & Sleep LLC.
3390 Paddocks Pkwy, Suite 200, Suwanee, GA 30024
770-615-0226
PATIENT INFORMATION

Date_____
First name_____Last_____M.I._____
Address _____
City/State/Zip_____Soc. Sec.#_____
Marital Status: S M D W Sex: M F Date of Birth_____/_____/_____ Age _____
Primary Phone _____ Secondary Phone _____
Employer_____ Email Address_____
Employer address_____

SPOUSE/GUARDIAN
Spouse/Guardian_____
Date of Birth_____/_____/_____ Employer Name_____
Soc Sec.#_____
Address (if different) _____
Home Phone_____Work Phone_____Cell Phone_____

EMERGENCY CONTACT
Name_____Relationship_____
Address_____Phone_____

Pharmacist Information:
Phone _____ Address: _____

INSURED OR RESPONSIBLE PARTY (POLICYHOLDER) INSURANCE INFORMATION Primary
Insurance Company_____
Policy Holder Name _____ Relationship to Patient _____
Soc. Sec.#_____ Date of Birth_____/____/_____
Member ID_____ Group Number_____ Effective Date _____
Employer_____Work Phone_____
Secondary Insurance Company _____
Policy Holder Name _____ Relationship to Patient _____
Soc. Sec.#_____ Date of Birth_____/____/_____
Member ID_____ Group Number_____ Effective Date _____ I hereby assign medical benefits to which I am entitled to this office, unless revoked by me in writing. I authorize any information needed to be released to my insurance company for the purpose of authorizing and processing my claims. I understand that I am fully responsible for, and will assume all my charges not paid by my insurance. **I UNDERSTAND THAT I WILL BE CHARGED IN FULL FOR ANY APPOINTMENTS NOT KEPT UNLESS 48 HOURS NOTICE IS GIVEN TO THE OFFICE**.

Signature of Patient/Guardian_____Date_____