

ADHD (Attention Deficit Hyperactivity Disorder) Group Meetings Registration Form

FOR ADULTS ONLY

Please return this form to our office by August 9, 2010 – Groups start in mid September

(Please Print)

Today's Date ____/____/____

Dr. Ross F. Grumet

PATIENT INFORMATION

Last Name			First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid / Domestic Partner		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)			Birth Date / /	Age	Gender	
Home Phone No. ()		Cell Phone No. ()		Social Security		Email Address		
Home address: Street Address			Apt #	City	State	ZIP Code		
Occupation		Employer			Employer Phone No. ()			
Chose Office Because/Referred to Office by (Please check one box)					<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> APS Website	<input type="checkbox"/> Other				

Other Family Members Seen Here _____

GROUP THERAPY INFORMATION

Have you ever attended a group therapy meeting before? Yes No

Have you ever attended an ADHD group meeting before? Yes No

IN CASE OF EMERGENCY

Name of Local Friend or Relative (<u>not living at same address</u>)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
--	-------------------------	-----------------------	-----------------------

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Psychiatric Specialists, P.C. or insurance company to release any information required to process my claims. I hereby give my consent for treatment by Dr. Ross F. Grumet. I have been given the opportunity to review the privacy practices of Atlanta Psychiatric Specialists, P.C. as required by HIPAA laws.

X _____
 PATIENT SIGNATURE DATE