

Patient Demographic Form

Newport Integrated Behavioral Healthcare, Inc

Please PRINT

1810 Moseri Rd. Decatur, GA 30032

MRN _____ Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Nickname/AKA _____

Date of Birth _____ Social Security Number _____ Gender Male Female

Marital Status Married Single Divorced Life Partner Separated Widowed Other Language other than English _____

Race (Optional) Black – Non Hispanic American Indian/ Alaskan Native Hispanic Asian/Pacific Islander White – Non Hispanic Other

Home Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Phone Cell Pager Fax

Email Address _____ Employment Status Active Duty Military Employed Full-Time Not Employed Student Full-Time Child Employed Part-Time Retired Student Part-Time Disabled Homemaker Self Employed Other

Employer _____ Employer Phone _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician _____ Referring Physician _____

How did you hear about us? Billboard Friend Magazine Physician Website Other Employer Health Fair Event Mail Radio Yellow Pages Family Member Insurance News Television

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient Self (If self, skip to Emergency / Next of Kin) Spouse Parent Other

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Social Security Number _____

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Home Phone _____ Work Phone _____ Other Phone Cell Pager Fax

Employer _____ Employment Status Active Duty Military Employed Full-Time Not Employed Student Full-Time Child Employed Part-Time Retired Student Part-Time Disabled Homemaker Self Employed Other

Employer Phone _____

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name _____ First Name _____ Relationship to Patient _____

Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Phone Cell Pager Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name _____ First Name _____ Relationship to Patient _____

Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Other Phone Cell Pager Fax

- If copies of insurance cards are not attached, please complete Patient Insurance Form
- Fax completed form and insurance cards to Registration Services at 404-2867009