Lifeline Psychiatry LLC
2150 Peachford Road, Suite K
Atlanta, GA 30338
770-458-0450 770-458-0470 (fax)
www.gapsychiatry.com

PATIENT INFORMATION			
Last Name	First		Middle
Birth Date		**Gender:**	Male/Female
Address	City, State, Zip code		
Home Phone #			
Mobile #	E-mail:		
Employment Status: Employed Full-time/Part-time	Unemployed	Disabled	Student Full-time/Part-time
School and/or Employer	Grade		
(*Optional)			
Ethnicity*	Religion*		Marital Status*
FINANCIAL INFORMATION			
Name of the person responsible for payments (Fill the details below)			
Last Name	First		Middle
Relationship to patient:		**Gender:**	Male / Female
Address			
City, State, Zip Code			
Phone #			
Email:			
OTHER CONTACT INFORMATION (if applicable)			
Emergency Contact: Name:			Ph:
FAMILY CONTACTS (Circle one if applicable)			
Biological Parent(s) / Adopted Parent(s) / Foster Parent(s) / Guardian(s) / Case worker			
Name:	Phone:		
Name:	Phone:		

I understand that I am responsible for making complete payments at the time of service and hereby authorize Lifeline Psychiatry LLC to use necessary individual and credit card information on file to process payments.

I was given the opportunity to review the privacy practices and clinic policies and I consent for treatment by Suneel Katragadda, MD and other providers working at Lifeline Psychiatry LLC.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____