

Ronald Magat MD, LLC
3830 Windermere Parkway Ste 304
Cumming, GA 30041

Patient Information Sheet

Patient Name (First/Middle/Last) _____ DOB _____

Responsible Party _____

Address _____

May I mail correspondence to above address? Y N

Home ph# _____ Cell ph# _____ Work ph# _____

Which number is best to call? HP CP WP Which number may I leave a message? HP CP WP

Email (optional) _____

Employer _____ Occupation _____

Marital Status: Single Married Divorced Widow/Widower Other

Spouse/Partner name (if applicable) _____

Current Household Members (please include ages and relationship to client)

In Case of Emergency Contact _____ Relationship _____

Phone# _____ Address _____

Referred by _____

Medical History

Brief Non-Psychiatric Medical History/Medical Problems

Current non-psychiatric medication(s) and dosage(s)

Non-Psychiatric Hospitalization(s)/Surgery and approximate date(s)

Allergies and reactions _____
Current doctors/specialists and numbers _____

Psychiatric History

Previous/current psychiatric medication(s), dosage(s), duration and reason for discontinuation

Previous Psychiatric Hospitalization(s) (location/dates)

Current/Previous Psychiatrist(s)/Therapist(s)

Reason for today's visit

**24 HOUR CANCELLATION NOTICE IS REQUIRED OTHERWISE YOU/YOUR
ACCOUNT WILL BE CHARGED FOR THE FULL RATE**

PERMISSION TO PROVIDE SERVICES/RESPONSIBILITY FOR PAYMENT: I hereby grant permission to Ronald Magat, MD to provide services to the above named patient and do hereby accept full and complete responsibility for all debts and obligations incurred during the course of treatment. I further agree to pay attorney's fees and interest if said debts are collected by or through an attorney-at-law or a professional collection agency.

Signature of Responsible Party _____

Signature of Patient _____ Date _____