Ronald Magat MD, LLC
3830 Windermere Parkway Ste 304
Cumming, GA 30041
(678)680-3972

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 _____

Pharmacy Information/Ph_____

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)
_____
_____
_____

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

_____
_____
_____

Allergies and reactions_____
Current doctors/specialists and numbers

_____
_____
_____
_____

Psychiatric History

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

_____
_____
_____
_____
_____
_____
_____

Previous Psychiatric Hosptialization(s) (location/dates)

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Reason for today's visit

_____
_____

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

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_____