Eamon Dutta, M.D.

AC4Wbilling@gmail.com

6100 Lake Forrest Drive, Suite 450 Atlanta, GA 30328 (404) 343-4162

Demographics Form

Date_____ Patient Name _____

Assigned gender at birth/Identified gender and preferred pronouns _____

Referral Source_____

Patient Date of Birth _____ Patient SS#_____-_____-_____

Address _____

Home Phone_____ Can we leave a message? Y N

Cell Phone _____ Can we leave a message? Y N Text message? Y N

Email Address _____ Can we email you? Y N

Current occupation_____Employer_____

Primary Care Doctor _____Therapist_____

Please list any other family members that may be involved in the treatment (in family meetings, etc.).

Please circle any name we may contact in an emergency situation

Name and relationship to pt.	Date of Birth	Phone, Email, and/or Address if different than pt.

Financially Responsible Party (Parent if patient is a minor)

Name _____ Relation_____

Address_____

Preferred Phone number _____

Email _____

Medical Information

Current Medications _____

Prescribing Doctor _____

I hereby authorize treatment by Eamon Dutta, M.D. I understand that I am responsible for all services regardless of insurance benefits or reimbursement. I authorize the billing department of Atlanta Center for Wellness, LLC to release information to process and secure payment for services.

****FULL FEE*** will be charged for appointments not cancelled twenty-four hours in advance.

*All billing questions should be sent to Kim Frey, admin, at AC4Wbilling@gmail.com or 678-984-6722

Patient or Guardian Signature _____

Financially Responsible Party _____

We are now sending monthly statements via email please confirm the email where you want to receive them:

_____