Grew, Morter & Hartye PA
3141 John Humphries Wynd, Suite 275
Raleigh, North Carolina 27612

CLIENT INFORMATION (Adult Client)

Name: _____
Last First Middle

Home Address: _____

_____

Home Phone:_____ *May we leave messages at this number? Yes No

Work or Cell Phone: _____ *May we leave messages at this number? Yes No

Employer / Occupation: _____ How Long at Current Job? _____

Date of Birth: _____ Age: _____ Gender: _____ Preferred Pronoun (he, she, they, other): _____

Ethnic Group (Optional): _____ Relationship Status: _____

Primary Care Physician _____ Phone: _____
*May your GMH provider contact your PCP in order to coordinate your care (a release form will need to be signed)? ___YES __NO (if No, please initial here): _____

EMERGENCY CONTACT(S):

Name: _____ Phone: _____ Relationship to Client_____

Name: _____ Phone: _____ Relationship to Client_____

RESPONSIBLE PARTY:

Name: _____
Last First Middle
Address: _____

_____
Home Phone: _____ *May we leave messages at this number? Yes No
Work or Cell Phone: _____ *May we leave messages at this number? Yes No
Employer: _____ Date of Birth: _____
Social Security #:_____ Subscriber ID#_____
Insurance Company: _____Group Number: _____
Insurance Customer Service or Member Benefits Phone Number: _____

RELEASE OF INFORMATION: I hereby authorize the release of any information necessary to process any insurance claims for payment. I understand that this may include detailed information regarding my condition and/or treatment. I understand that I am responsible for payment of GMH fees if the insurance company denies payment on claims. **I understand that I am responsible for payment of late cancellation/missed appointment fees of $69.**

SIGNATURE _____ DATE: _____
Print Name of Peson Signing:_____