Darren Meyer, M.D., Praveen Moolamalla, M.D.
and James Lawhorn, MS, LPC

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name: **First:** **Middle:**			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):		**Birth date:** / /	Age:	**Sex:** ❑ M ❑ F
Social Security:	**Home phone:**			**Cell phone:**		
Mailing Address:	**City:**			**State:**	**Zip code:**	
E-mail:	PCP:					
Other family members seen here:						

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone:	Work or cell phone:

PRIMARY INSURED INFORMATION

(Fill out only if primary insured is different from patient.)

Name of primary insurance:				
Subscriber's name:	Birth date: / /	Social Security:	Home phone:	
Mailing Address (if different):	P.O. Box:	City:	State:	Zip code:
Name of secondary insurance:				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Darren Meyer, and Dr. Praveen Moolamalla to release to my insurance company any information required to process my claims.

Patient/Guardian signature *Date*