ADULT REGISTRATION FORM

Name _____ **Sex** _____ **Age** _____ **D.O.B.**_____

Address_____ **Home Phone** _____

City _____ **State**_____**Zip** _____

Occupation _____ **Cell Phone** _____

Employer_____ **Work Phone** _____

Marital Status (Circle) Single Married Divorced Widowed

Spouse's Name: _____ **Cell Phone** _____

Spouse's Occupation _____ **Employer** _____

Primary Care Doctor _____

Who Referred You to Dr. Walker _____

- **I may be charged for appointments not canceled 24 hours in advance.**
- **I am responsible for fees for services. Outstanding balances on my account may be submitted to collections after thirty (30) days.**

Patient Signature _____ **Date** _____

Patient Email Address _____

Medicare Insurance

Insured's Name _____ **D.O.B.** _____

Insured's Contract I.D._____

Insured's Relationship to Patient: (Circle) Self Spouse Parent
Insured's Status: Married Single Widowed Divorced

I authorize the release of my Protected Health Information to process my insurance claim and authorize payment of medical benefits to Robyn L. Walker, Ph.D. for services rendered. I understand that I am responsible for fees if my insurance company fails to reimburse as expected.

Patient Signature _____ **Date** _____