



ROBERT M. MEYER, M.D.

Diplomate, American Board of Internal Medicine

PATIENT REGISTRATION

PATIENT NAME Last First Initial

HOW DID YOU HEAR ABOUT US

Home Address

City State Zip DOB

Mailing Address (if different)

Male/Female Social Security Number Marital Status

Home Phone Cell Phone E-mail

Employer Occupation Work Phone

Friend or Relative not Living With You:

Name Relationship

Address Telephone

Medical Insurance Information:

1. Primary Insurance Policy Holder

2. Secondary Insurance Policy Holder

Pharmacy Information:

Address Phone

Name of Spouse or (if a minor) parent

Spouse's/Parent's Employer Telephone

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payor to pay directly to Meyer Internal Medicine all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Meyer Internal Medicine to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the providers at Meyer Internal Medicine which may be due me from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. This authorization and assignment shall be valid until I notify Meyer Internal Medicine in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature

Date

Signature (WITNESS)

Date

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