(404)585-7375
1244 Clairmont Road,Suite 218 Decatur, GA 30030

COMPLETELY PSYCHED

It is time to step outside of your box.

REGISTRATION FORM

Please Print

CLIENT INFORMATION

Client's Name - Last: 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	
Street address:		Social Security:		Home phone : ( )		
P.O. box:	City:	State:		ZIP Code:		
Occupation:	Employer:			Employer phone: ( )		
Referred by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Internet	❑ Yellow Pages	❑ Other		
Other family members seen here:						

BILLING INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone : ( )	
Is this person a client here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone: ( )	
Is this client covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. John W. Wilson. I understand that I am financially responsible for any balance. I authorize Dr. John W. Wilson or insurance company to release any information required to process my claims.

Client/Guardian signature ***Date***