Dr. Lori Lyles & Associates

Midlife Healthcare Consulting | Weight, Hormone Replacement, Aesthetics

PLEASE PRINT CLEARLY

Last Name_____ **First Name**_____ **Middle Initial**_____

Preferred Name: _____ **Date of Birth:** _____ **Age:** _____

Mailing Address: _____

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

Home Phone _____ **Work Phone** _____ **Cell Phone**_____

Sex: Female Male **Marital Status:** Single Widowed Married Divorced Separated

E-mail Address: _____

EMPLOYER INFORMATION

Employer Name: _____ **Occupation:** _____

EMERGENCY CONTACT

Name: _____ **Phone:** _____

Relationship: _____

Primary Care Physician: _____

Name Phone Number

Whom may we thank for the kind referral? _____

We have elected to "opt out" of Medicare. Therefore, you are unable to file for Medicare reimbursement for any of our services.

I understand that I am financially responsible to Dr. Lori Lyles & Associates for all charges. Payment is due at time services are rendered.

_____ _____

Responsible Party Signature Date

1220 Hospital Drive Mt. Pleasant, SC 29464 Phone (843)388-8222 Fax (843)375-8808