

(The patient completes all information requested **except when indicated.**)

Patient Name \_\_\_\_\_

Please complete in ink and return at seminar.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

<b>New Patient Information</b>		Name	Date of Birth	Gender (circle one) Male · Female
Address/City/State/Zip				
Home Phone		Cell Phone	Social Security No.	
Marital Status (circle one) Single · Married · Divorced · Widow · Other			E-mail Address*	
Employer			Work Phone	
Emergency Contact			Emergency Contact Phone	
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Internet · Direct Mailer · Other				

<b>Insured Party Information</b>		Responsibility Party Name (if patient is under 18 OR other than patient)		
Address/City/State/Zip				Social Security No.
Phone	Date of Birth	Employer Name & Phone No.		

<b>Physician Information</b>		Referring Physician/PCP (First Name, Last Name)		Phone
Address/City/State/Zip			Email	Fax
Pharmacy:				Phone

<b>Insurance Information</b>		Primary Insurance		
Primary Insurance Address/City/State/Zip				
Policyholder Name (if other than patient)			Social Security no	
ID/Policy No	Group No		Primary Insurance Phone	
Secondary Insurance				Phone
Policy holder name(if other than patient)			Social security no	
ID/Policy No			Group #	

A copy of both sides of the insurance cards needs to accompany this form.

I authorize my insurance company to pay directly any and all claims submitted by Scottsdale Healthcare Bariatric Center, PLC. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

Signature\*\* \_\_\_\_\_ Date \_\_\_\_\_

\* My signature on this document allows Scottsdale Healthcare Bariatric Center to communicate to me via my e-mail address.

\*\* My signature on this document allows Scottsdale Healthcare Bariatric Center to request copies of any and all medical records from any source pertinent to my medical care.