



01/05/2010

PATIENT REGISTRATION AND PREFERENCES REGARDING PROTECTED HEALTH INFORMATION

COMMUNICATION PREFERENCES

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer Phone: _____

Occupation: _____

City: _____ State: _____ Zip: _____

Social Security #: _____

Age: _____ Birth Date: _____

Can we contact you here? Can we leave a message?

Y N Home: _____ Y N

Y N Mobile: _____ Y N

Y N Work: _____ Y N

Y N Email: _____

Y N Other: _____

Marital Status: S M D W Sex: M F

Other than you, your insurance company and healthcare providers involved in your care, whom can we talk with about your healthcare information?

Name: _____ Relationship: _____ Phone: _____

May we send mail to your home? Yes No

Emergency Contact: _____

Emergency Phone: _____

I HAVE ATTENDED A LIVE OR ON-LINE GASTRIC BAND SEMINAR

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber Birthdate: _____

Subscriber Social Security #: _____

ID #: _____ Group #: _____

Claims Mailing Address: _____

Insurer Website Address: _____

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber Birthdate: _____

Subscriber Social Security #: _____

ID #: _____ Group #: _____

Claims Mailing Address: _____

Insurer Website Address: _____

Relationship to Patient: Self Spouse Child

Relationship to Patient: Self Spouse Child

I authorize Weight Loss Surgical Center to bill my insurance company. If my insurance company does not offer bariatric benefits, I understand that Weight Loss Surgical Center may occasionally attempt a courtesy bill to my insurance company.

PLEASE READ CAREFULLY

I hereby authorize release of any information obtained in the course of my registration, interview, examination and treatment necessary to file a claim with my insurance carrier as per HIPAA privacy practices. I authorize payment directly to WEIGHT LOSS SURGICAL CENTER benefits otherwise payable to me for services as described. I understand I am financially responsible for charges not covered by my insurance including but not limited to medical services deemed routine, elective, or not medically necessary by my insurance company and/or any co-pays, deductibles, co-insurance amounts or non-covered items specified by my insurance company. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of this signature is valid as the original.

DATE: _____ PATIENT SIGNATURE: _____ INSURED'S SIGNATURE: _____



PATIENT INFORMATION SHEET

Please complete before your appointment

At your first visit, you will have a packet of paperwork to fill out regarding your health history. Some of these items may require a bit of research, so please be sure that you have the following details with you when you arrive at the office. If it is helpful to you, you may take notes on this sheet.

Primary Care Doctor

Name
Specialty
Phone
Address
City
State
Zip

Specialist List (all doctors who have assisted you with weight loss or are involved in your medical care)

Name
Specialties
Reasons Seen
Phones
Addresses
Cities
States
Zips
Office Phone

Surgical History (all surgical procedures you have had done.)

Surgery
Year
Surgeon Name

Current Medications (all current medications with dosages)

Drug Allergies or Reactions