DEMOGRAPHIC AND INSURANCE INFORMATION

LifeWeigh Bariatrics
Healthy Living Through Teamwork

PATIENT INFORMATION RECORD

Please complete prior to your first appointment.

Patient Name:_____
Last Name First Name Middle Initial

Social Security Number (SSN#):_____

Home Address:_____

City/State/Zip Code:_____

Date of Birth: _____ Age: _____ Sex: Male ___ Female ___

Martial Status: Married ____ Single ____ Divorced ____ Widowed____

Home Phone: (_____) _____Work Phone: (_____) _____

Cell Phone: (_____) _____ Other (_____) _____

E-mail: _____

Referred By: _____ (if physician, full name)

Best number to be reached during the day (please circle one):

Home Work Cell Other

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE CARD)

Medicare HMO PPO No insurance / Self pay Other_____

Subscriber's Name:_____
Last Name First Name

Subscribers Social Security # _____

Subscriber's Date of Birth:_____

Policy ID#: _____ Group#: _____

Subscriber's relationship to Patient: _____

SECONDARY INSURANCE (IF APPLICABLE)

Medicare HMO PPO No insurance / Self pay Other _____

Subscriber's Name: _____
Last Name First Name

Subscribers Social Security # _____

Subscriber's Date of Birth:_____

Policy ID#: _____ Group#: _____

Subscriber's relationship to Patient: _____

REFERRAL INFORMATION

Referring Physician: _____

Phone Number: _____

Primary Physician (if different from above): _____

Phone Number: _____

Is your insurance through your Employer? _____ Yes _____ No

If yes, Name of Employer: _____ Are you ☐ full-time or ☐ part-time?

DRIVER'S LICENSE

Drivers License Number: _____

State: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone number:_____

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NON-MEDICARE PATIENTS, PATIENTS WITH A MANAGED CARE INSURANCE, PRIVATE INSURANCE OR NO INSURANCE, PLEASE SIGN THIS SECTION

COMMERCIAL INSURANCE, MANAGED CARE AND SELF INSURED MEMBERS LIFETIME AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I assign and request that benefits payable for physician services be made directly to LifeWeigh Bariatrics. I request that this authorization apply to all insurance claims, present and future, for this physician group.
I understand that I am responsible for payment of any balance not paid by my insurance company.

_____
DATE PRINT PATIENT (OR INSURED'S) NAME

_____
SIGNATURE OF PATIENT (OR INSURED)

PLEASE BRING REFERRAL AND INSURANCE CO-PAY (IF APPLICABLE) TO THE FRONT DESK WHEN RETURNING THIS FORM. THANK YOU.

Release of Information: I authorize the release of any medical information necessary to process this claim or provide medical information to any physician or medical facility.

Printed name:_____

Signed by Patient or authorized Guardian: _____

Date:_____

Specific release for mental health, drug or alcohol abuse or HIV information:
1) I hereby specifically authorize information that may include mental health, drug or alcohol abuse or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons and organizations and for the purpose stated in Release of Information above.
2) By initialing the diagnosis(es)/condition(s) below, I do not consent to the release of such medical information, if any, to third party payors and understand I am personally responsible for payment.
Mental Health_____ Drug and Alcohol Abuse_____ HIV_____
Disclosure is limited to:
1) Records regarding admission and treatment for the following medical condition or injury:
_____
2) Records for the period (dates) from _____ to _____
3) The following specified information: _____
4) No limitations placed on dates, history of illness, or diagnostic and therapeutic information.

Consent for Treatment:
I (we) voluntarily request treatment from Dr. Rosen and his associates for the treatment of my condition. This treatment may include physical exam, blood tests, EKG, pulmonary function test, urinalysis, Lap Band adjustment, wound/incision care.
I allow Dr. Jeffrey Rosen and LifeWeigh to enter my medical information into the quality improvement module for a clinical integration program if Dr. Rosen or his appointee feels this is appropriate. This information allows physicians to determine quality of care while providing privacy protection for the patient.

Signature of patient_____ Date_____

Printed name of patient_____
