

PATIENT INFORMATION

NAME: _____

PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

AGE: _____

SEX: _____ MALE _____ FEMALE _____ SINGLE _____ MARRIED _____ WIDOWED _____

DIVORCED _____

PATIENT EMPLOYED BY: _____

WORK NUMBER: _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____

REFERRED BY: _____

INSURANCE

INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

INSURANCE ADDRESS: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____

SS #: _____

ADDITIONAL INSURANCE COMPANY: _____

POLICY #: _____

GROUP #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Bariatric & Advanced Surgical Specialists, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give my consent to Bariatric & Advanced Surgical Specialists, LLC to release any and all medical information to any doctor and/or hospital that I may be referred to by Bariatric & Advanced Surgical Specialists, LLC.

SIGNATURE ON FILE: _____

DATE: _____

(PATIENT OR LEGAL GUARDIAN)