

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date: _____

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Employer Tel #: (_____) _____

Occupation: _____

City: _____ State: _____ Zip: _____

Social Security #: _____

Age: _____ Date of Birth: _____

Marital Status: _____ Sex: M F

Home Phone: (_____) _____

Work Phone: (_____) _____

Mobile Tel #: (_____) _____

E-Mail Address: _____ @ _____

Emergency Contact Name: _____

Emergency Phone: (_____) _____

INSURANCE INFORMATION (Subscriber is the individual under whose name the family or individual is insured.)

Primary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber DOB: _____

Subscriber Social Security #: _____

ID#: _____

Group#: _____

Claims Mailing Address: _____

Insurer Website Address: _____

Relationship to Patient: Self Spouse Child

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber DOB: _____

Subscriber Social Security #: _____

ID#: _____

Group#: _____

Claims Mailing Address: _____

Insurer Website Address: _____

Relationship to Patient: Self Spouse Child

PLEASE READ THE STATEMENT BELOW 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. Furthermore, I authorize payment directly to the Institute for Advanced Bariatric Surgery at the Minimally Invasive Surgery Hospital of the benefits otherwise payable to me for services as described. I am responsible for any amount not covered by insurance except that which is limited by contract between the institute and the insurer. I understand that the office reserves the right to bill finance charges at 1½% per month on patient balances unpaid after 60 days. 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.

DatePatient SignatureInsured's Signature