Demographic & Insurance Information

Patient Name_____
Last First Middle Initial
Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell #**_____ **Work #**_____

Date of Birth_____ **SSN**_____ **E-Mail**_____

Current height _____ **Current weight** _____ ☐ **Male** ☐ **Female** **Marital Status** ☐ **Single** ☐ **Married**
(Must have) (Must have)
Spouse's Name_____ **Spouse's D.O.B** _____ **Spouse's SSN**_____

Are you employed? ☐ **Yes** ☐ **No** **IF YES, Company Name**_____
Your Employer's Address_____

Are you interested in Bariatric Surgery? **Yes** _____ **No** _____
Are you interested in a Non-Surgical Program? **Yes** _____ **No** _____
Have you ever been a patient of Deaconess Weight Loss Solutions? **Yes** ____ **No** ____ **If YES, when?** _____
Have you ever had bariatric surgery before? **Yes** _____ **No** _____
If YES to the above question: Which type of surgery did you have, what year did you have it, and what was your Surgeons name? _____

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Responsible Party – if other than the Patient (the policyholder of the medical insurance)

Name_____
Last First Middle Initial
Street Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell #**_____ **Work #**_____

Date of Birth_____ **SSN**_____

☐ **Male** ☐ **Female** **Marital Status** ☐ **Single** ☐ **Married** **Other**_____

Are they employed? ☐ **Yes** ☐ **No** **IF YES, Company Name**_____

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Emergency Contact Name _____ **Phone** _____
Relationship to the patient_____
PCP or Referring Physicians Name_____ **Phone** _____

Please complete the back of this form in order for us to accurately verify your insurance information

Data Sheet – Insurance Information – Please Write Legibly

NAME OF PRIMARY INSURANCE COMPANY_____

Insurance Phone Numbers_____
(We must have this to contact them - Customer Service and/or Provider and/or Precertification, etc.)

Member's I. D. #_____ **Group #**_____

Name of the person listed as the policyholder for this primary insurance policy: _____

Relationship to the patient_____

Policyholder's Date of Birth_____ **Policyholder's SS#**_____

Company or organization the policyholder is (or was) employed by_____

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NAME OF SECONDARY INSURANCE COMPANY_____

Insurance Phone Numbers_____
(We must have this to contact them - Customer Service and/or Provider and/or Precertification, etc.)

Member's I. D. #_____ **Group #**_____

Name of the person listed as the policyholder for this secondary insurance policy: _____

Relationship to the patient_____

Policyholder's Date of Birth_____ **Policyholder's SS#**_____

Company or organization the policyholder is (or was) employed by_____

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NAME OF TERTIARY INSURANCE COMPANY _____

Member's I.D. # _____ **Group #** _____

Name of the person listed as the policyholder for this tertiary insurance policy: _____

Relationship to the patient_____

Policyholder's Date of Birth_____ **Policyholder's SS#**_____

Company or organization the policyholder is (or was) employed by_____