

Demographic & Insurance Information

Patient Name _____

Street Address _____
Last First Middle Initial
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 our non-surgical Healthy Eating and Living Program? Yes _____ No _____

Are you interested in Bariatric Surgery? 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? _____

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 _____

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 _____

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 _____

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 _____