



**SEMINAR DATE:** \_\_\_\_\_

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Can we leave message? Home: Y / N Work: Y / N Cell: Y / N Email: Y / N

Male:  Female:  Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Current Height:** \_\_\_\_\_ft\_\_\_\_\_in      **Current Weight:** \_\_\_\_\_lbs

**Insurance Information:**

Carrier Name: \_\_\_\_\_ Customer Svc Phone Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy DOB: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Group Number: \_\_\_\_\_

**ID, Member, or Policy number:** \_\_\_\_\_

I authorize Sun Coast Bariatrics to verify my insurance benefits. I authorize the release of insurance payments directly to Sun Coast Bariatrics and allow Sun Coast Bariatrics to release any information obtained in the course of my evaluation and treatment to permit processing of claims for insurance reimbursement. A photocopy of my signature is valid.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_