

ST. JOHN WEIGHT LOSS CENTER

Patient Registration

Patient's Name: Last			First	Middle	Social Security #		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Birth Date	Age	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Email Address				
Street Address								
P.O. Box			City		State	Zip Code	Home Phone #	
Cell Phone #		Occupation		Employer			Work Phone #	
Primary Care Physician				Primary Care Physician Address				
Primary Care Physician Phone #			Referred By (Physician Name)			Referring Physician Phone #		
Referring Physician Address						Height Ft.	In.	Current Weight
How did you learn about ST. JOHN WEIGHT LOSS CENTER? <input type="checkbox"/> Friend/ Relative <input type="checkbox"/> PCP <input type="checkbox"/> Website <input type="checkbox"/> Radio <input type="checkbox"/> Print <input type="checkbox"/> Other Physician <input type="checkbox"/> Other: _____								

Insurance Information

Primary Insurance Name:				Subscriber Name:			
Subscriber SS#:		Subscriber D.O.B.		Contract Number		Group Number	
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:							
Secondary Insurance Name:				Subscriber Name:			
Subscriber SS#		Subscriber D.O.B.		Contract Number		Group Number	
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:							

Emergency Contact- please list three

Name of Friend or Relative Not Living at same Address	Relationship to Patient	Home Phone

The above information is true to my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am responsible for any balance. I authorize St. John Weight Loss Center or my insurance company to release any information required to process my claims.

X _____ Patient/ Guardian Signature	Date: _____
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