

# REGISTRATION FORM

(Please Print)

## PATIENT INFORMATION

Patient's Name Last				First	Middle	Social Security #	Spouse Name
Birth Date	Age	<input type="checkbox"/> M	<input type="checkbox"/> F	E-mail Address			Cell Phone #
Street Address						Home Phone #	
P.O. Box			City		State	ZIP Code	
Occupation			Employer			Work Phone #	
Primary Care Physician:					Phone #:		
Address:			City		State	ZIP Code	
Referred by (Physician Name):					Phone #:		
Address:							
Other Physicians you are currently under care of::					Phone #:		
Other Physicians you are currently under care of::					Phone #:		
How did you learn about Dr Roslin and the NWH Surgical Weight Loss program? <input type="checkbox"/> Friend / Relative <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Website <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Print <input type="checkbox"/> Other Physician _____ <input type="checkbox"/> Other: _____							

## INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Please name primary insurance:				Phone Number:		
Group #:		ID #:				
Subscriber's Name		Subscriber's S.S. #		Birth Date		
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Please name secondary insurance:				Phone Number:		
Group #:		ID #:				
Subscriber's Name		Subscriber's S.S. #		Birth Date		

Patient's Relationship to Subscriber  Self  Spouse  Child  Other

**IN CASE OF EMERGENCY**

**Please fill in box #1 for person to contact in case of emergency**

**Please fill in box # 2 & 3 for contacts where we might leave a message**

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone #	Work Phone #
1.		(    )	(    )
2.		(    )	(    )
3.		(    )	(    )

The above is true and correct to the best of my belief. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr Roslin and NWH Surgical Weight Loss program to release any information required in order to process my request for insurance authorization, and for claims, to my primary care/other physician, or insurance company .

X	
<b>PATIENT/GUARDIAN SIGNATURE</b>	<b>DATE</b>