Southwest BARIATRIC Surgeons

PATIENT INFORMATION

Even though we will copy your insurance cards, please complete all of the information requested below.

PCP/FAMILY PHYSICIAN: ______________________ REFERRED BY: ______________________

Patient's Name: ______________________ Social Security #: ______________________
Last *First* *Middle*

Date of Birth (MM/DD/YY): ____ / ____ / ____ Age: ______ Sex: _______ Marital Status: _____________ Driver's License: __________________

Home Address: ____
City *State* *Zip Code*

Home Phone: ( ) ______________________ Work Phone: ( ) __________________ Other (Cell/Pager) __________________

Employer: ______________________ Work Address: ______________________
City *State* *Zip Code*

Occupation: ______________________ Email: ______________________

IN CASE OF EMERGENCY, NOTIFY: ______________________ Relationship: ________________ Phone(s): ( ) ________________

INSURANCE INFORMATION

** If the patient has HMO insurance, a referral from the PCP is required to allow the patient to be seen by our group. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self-pay basis.

Primary Insurance: ______________________ ☐ HMO ☐ PPO ☐ Other ID # ____________ Group # ______________

Subscriber's Name: ______________________ *Subscriber's SS #* ______________________ *Subscriber's Date of Birth:* ____ / ____ / ____

Subscriber's Employer: (☐ Same as above) ______________________ Work phone: ______________________

Claims Address: ____
City *State* *Zip Code*

Primary Insurance Phone #: ______________________ Subscriber's Relation to Patient: ____________________

Secondary Insurance: ______________________ ☐ HMO ☐ PPO ☐ Other ID # ____________ Group # ______________

Subscriber's Name: ______________________ *Subscriber's SS #* ______________________ *Subscriber's Date of Birth:* ____ / ____ / ____

Subscriber's Employer: (☐ Same as above) ______________________ Work phone: ______________________

Claims Address: ____
City *State* *Zip Code*

Secondary Insurance Phone #: ______________________ Subscriber's Relation to Patient: ____________________

IS THIS A WORK RELATED INJURY? _________ *IF YES, PLEASE PROVIDE FOLLOWING INFORMATION:*

Claim Adjustor's Name: ______________________ Phone: ______________________ Date of Injury: ___________

Claim Number: ______________________ Contact at Employer: ______________________ Contact's phone: ________________

RESPONSIBLE PARTY INFORMATION (*If other than patient*)

Guarantor's Name: ______________________ Guarantor's Social Security #: ______________________
Last *First* *Middle*

Guarantor's Date of Birth (MM/DD/YY): ____ / ____ / ____ Sex: _______ Marital Status: ___________ Driver's License: ____________________

Home Address: ____
City *State* *Zip Code*

Home Phone: ( ) ______________________ Work Phone: ( ) __________________ Other (Cell/Pager) __________________

Employer: ______________________ Work Address: ______________________
City *State* *Zip Code*

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Southwest Bariatric Surgeons all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby acknowledge that I have been presented a copy of the Southwest Bariatric Surgeons Notice of Privacy and Practices.

X ______________________ ______________________ ______________________

PATIENT SIGNATURE (or GUARDIAN if patient is a minor) **RELATIONSHIP** **DATE**