Worthy Weight Loss

PATIENT REGISTRATION FORM

HOW DID YOU HEAR ABOUT US?					NICKNAME		
PATIENT'S FULL NAME					MAIDEN NAME		
PHYSICAL ADDRESS		APT. NO.			HOME NUMBER		May we leave detailed messages? (Yes) (No)
CITY		STATE		ZIP		BUSINESS PHONE	May we leave detailed messages? (Yes) (No)
GENDER: ❑ F ❑ M	MARITAL STATUS	❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ WIDOWED ❑ OTHER	DATE OF BIRTH			CELL PHONE	May we leave detailed messages? (Yes) (No)
EMPLOYMENT STATUS	❑ FULL-TIME ❑ PART-TIME ❑ OTHER ❑ STUDENT					PATIENT'S SOCIALSECUIRTY	
PATIENT'S EMPLOYER NAME						PATIENT'S EMAIL ADDRESS	
EMPLOYER'S ADDRESS							
SPOUSE/GUARDIAN NAME		PHONE #		DATE OF BIRTH		SOCIAL SECURITY	
SPOUSE'S EMPLOYER					ADDRESS		
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP				PHONE NUMBER	

PRIMARY INSURANCE COVERAGE

NAME OF INSURED		INSURED DOB	❑ SELF ❑ PARENT ❑ SPOUSE ❑ OTHER		
INSURED'S EMPLOYER				WORK PHONE:	
EMPLOYER ADDRESS					
INSURANCE COMPANY		CO-PAY AMOUNT		CO-INSURANCE %	
INSURANCE CLAIMS ADDRESS				INSURANCE PHONE NO.	
CITY		STATE		ZIP	
POLICY NUMBER		GROUP NUMBER		INSURED'S SOCIAL SECURITY	

SECONDARY INSURANCE COVERAGE

NAME OF INSURED		INSURED DOB	❑ SELF ❑ PARENT ❑ SPOUSE ❑ OTHER		
INSURED'S EMPLOYER				WORK PHONE	
EMPLOYER ADDRESS					
INSURANCE COMPANY		CO-PAY AMOUNT		CO-INSURANCE %	
INSURANCE CLAIMS ADDRESS				INSURANCE PHONE NO.	
CITY		STATE		ZIP	
POLICY NUMBER		GROUP NUMBER		INSURED'S SOCIAL SECURITY	

CONSENT FOR TREATMENT, INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Worthy Weight Loss, PA and its provider(s) to render all necessary medical care and treatment to me or my dependent (child or other). I also authorize the physician, based on his/her discretion, to access my chart for managing my (or my dependent's) health care. I further authorize Worthy Weight Loss, PA to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Worthy Weight Loss, PA and its providers. I understand that I am ultimately responsible for all services whether covered by my insurance company or not. I understand that my co-payment, co-insurance, or fee for service, is due at the time of service. I also understand that not all services will be covered by my insurance company and I will be expected to pay for services that are not covered at the time the service is rendered. I understand that if my deductible has not been met at the time of service, I will be responsible for such amounts up to the fee for service at the time of service.

Date: _____ Patient Signature:_____ Relationship to Patient:_____