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				DATE OF BIRTH		PHONE NUMBER	
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			

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 carrier or not. I am responsible for determining what my insurance carrier will pay for and understand that Worthy Weight Loss, PA will submit a claim for my services to my insurance carrier as a courtesy. 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. 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:**_____