

UPMC HORIZON BARIATRIC SURGERY CENTER

*** Please complete entire form prior to your appointment***

For office use only:

Seminar Date _____

Presenter: JJK EM CJM

Ht _____ Wt _____ BMI _____

Patient Information:

Last name, first, middle initial	Date of Birth	Sex	Marital Status: M D S W
Street Address	Home Phone:		E-mail Address:
City State Zip Code	Work Phone:		Cell Phone Number:
Social Security Number:	Do you smoke?		Race

Employer Information:

Occupation / Type of Work	Employer's Street Address
Employer's Name	City State Zip Code

Emergency Contact Information:

Emergency Contact Name: Relationship:	Emergency Contact Home Phone Number:
Emergency Contact Address:	Emergency Contact Alternate Phone Number:

Primary Care Physician:

Primary Care Physician:	Primary Care Physician Address:
	Primary Care Physician Phone Number:

Referring Physician: (If different than Primary Care Physician)

Referring Physician:	Referring Address:
	Referring Phone Number:

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID Number	Policy or ID Number
Subscribers Name Date of Birth	Subscribers Name Date of Birth
Relationship to Patient	Relationship to Patient
Subscriber's Employer	Subscriber's Employer

I authorize release of medical information necessary to process claims for health insurance and disability benefits.

A copy of this authorization will be accepted as valid as the original.

Signature: _____ **Date:** _____

