

SOLUTIONS FOR LIFE SURGICAL WEIGHT MANAGEMENT PROGRAM

Phone: (316) 689-6115

Fax: (316) 689-5217

Patient Information:

Last name, first, middle initial		Date of Birth	Sex	Marital Status M D S W	
Street Address		Home Phone		Email Address	
City	State	Zip code	Work Phone		Telefax Number
Social Security Number		Employer's Name			
Spouse's Name (If applicable)		Employer's Street Address			
Spouse's Social Security Number		City	State	Zip code	
Emergency Contact:		Relationship	Occupation		
Home Phone	Work Phone	Referring Physician		Telephone 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	Subscribers DOB	Subscribers Name	Subscribers DOB
Relationship to Patient		Relationship to Patient	
Subscriber's Employer		Subscriber's Employer	

How did you hear about us? Lecture Friend Internet TV

(Circle one and complete information)

Doctor _____ Other _____

Have you ever received treatment to lose weight at Solutions for Life? No Yes

If yes, When? _____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. I agree to be responsible for payment for services rendered and for any additional expenses necessary to collect payment. A copy of this authorization will be accepted as valid as the original.

Signature: _____ Date: _____