REGISTRATION FORM

(Please Print)

Today's Date:	PCP Name:	PCP Telephone #:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

E-Mail Address (For Support Group & News letter info):	Social Security no.:	Home phone No. // Cell Phone No.:

Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ TV	☐ WEB	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(IF YOU ARE SELF PAY PATIENT YOU DO NOT HAVE TO FILL OUT THE SECTION BELOW)

Please give your insurance card to the receptionist.

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician or thier agents. I authorize Cincinnati Weight Loss Center, a Synchrony Health Network (CWLC) or its agents to bill my insurance company on my behalf. I understand that I am financially responsible for any balance and will not withhold or delay payment if my insurance company denies payment on any charges. I understand that there is a $40 fee on checks returned from any bank for insufficient funds. I also authorize CWLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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