MOREHOUSE HEALTHCARE

Patient Contact Information
Insurance Verification

General Surgery & Bariatric Surgeon: Johnson ☐ Hobson ☐

PATIENT INFORMATION **Date: _____**

First Name: _____ **Middle Initial**: _____ **Last Name:** _____

Social Security Number:_____**Employer:**_____

Address: _____ **Apt#**: _____

City: _____ **State**: _____ **Zip**: _____**Gender**: M ☐ F ☐

Date of Birth: _____ **Race**: Black ☐ White ☐ Asian ☐ Hispanic ☐ Other _____

Telephone: Home: _____ Mobile: _____ E-mail: _____

Contact Preference: Home ☐ Mobile☐ Work☐ E-mail☐ **Language**: English ☐ Other _____

Married ☐Single ☐Divorced ☐Widow ☐Partner Relationship ☐Children/Ages _____

Primary Care Physician: _____ Office #: _____

Referring Physician: _____ Office #: _____

EMERGENCY CONTACT

Full Name: _____

Phone: _____ M ☐ F ☐ Relationship:_____

INSURANCE: YES ☐ *Fill out info below* NO ☐ *I will pay out of pocket*

Does your insurance cover bariatric surgery? Yes☐ No☐ N/A ☐

Name of Insurance: _____ HMO☐ PPO☐ POS☐
ID#: _____ **Group #**: _____
Phone #: _____ **Insurance Address**:_____

Policy Holder: You☐ Spouse☐ Parent/Legal Guardian☐

Policy Holder Name:_____ Policy Holder DOB:_____
Name of Employer: _____

Do you have a secondary insurance? Yes☐ No☐ Phone #: _____

Name of Insurance: _____ HMO☐ PPO☐ POS☐
ID#: _____ **Group #**: _____

Policy Holder: You☐ Spouse☐ Parent/Legal Guardian☐ **Policy Holder DOB**:_____
Name of Employer: _____ **Insurance Address**:_____

For Office Use Only

Current Bariatric Benefits? Yes □ No □
Deductible Amount:_____ ***Interested in Cash Svcs.? Yes □ No □***
Out of Pocket Maximum:_____ ***Method of Payment:_____***