Diabetes and Endocrinology Specialists Inc.
&
Weight Loss Clinic

Today's Date: ____________________

PATIENT INFORMATION

(Please Print)

First Name:__________________________ Last Name: __________________________Middle Initial: _______

Date of Birth:____________________ Gender: ___F__-_ M _ SS#:___________________________

Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widow/er ( ) Minor

Home Address Street:____

City:_________________________State:____________Zip:________________________

Select Preferred Contact Method: ☐ **SMS (text message)** ☐ **E-mail** ☐ **Phone**

Home Phone #: ____________________________ Cell Phone #:__________________________

E-mail Address:____

WORK INFORMATION

Company Name: ____________________________________ Occupation:________________________________

Address:____ Work Phone #: ________________

IN CASE OF EMERGENCY

Name of person to notify in an Emergency: ________________________ Relationship: ______________________

Home Phone: __________________________ Cell Phone #: __________________________________

INSURANCE INFORMATION

(Please give you insurance card to the receptionist)

1. **Primary Insurance Information**:____

   Subscriber Name: _______________________ Relationship to Subscriber:___________________

   Date of Birth: ___________________ SS#: __________________________________

2. **Secondary Insurance Information (if applicable)**: ___________________________________

   Subscriber Name: _____________________ Relationship to Subscriber:____________________

   Date of Birth: ___________________ SS#:__________________________________

Diabetes and Endocrinology Specialists Inc.
&
Weight Loss Clinic

Acknowledgment Consent Form

Initial

- We accept most major insurances. The patient is responsible for his/her co-pays and yearly deductibles.
  It is patient's responsibility to find out the deductible in advance. ________

Initial

I,____ undersigned, have insurance coverage with above named carriers, and assign directly to: **Diabetes and Endocrinology Specialist Inc.** all surgical and/or medical benefits including any major medical benefits, if any, otherwise may able to me for services rendered. ________

I understand that I am financially responsible for all charges whether or not paid by insurance. ________

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. ________

Insurers or Guardian's **Signature: ______________________________ Date: ________________**