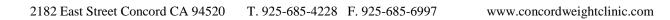


Diabetes and Endocrinology Specialists Inc. & Weight Loss Clinic

Today's Date: \_\_

PATIENT INFORMATION				
	(Please Print)			
First Name:	Last Name:	M	iddle Initial:	
Date of Birth: Ge	ender:F M	SS#:		
Status: () Married () Single () Div	vorced () Separated (	) Widow/er () M	inor	
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:	Occupa	ation:		
Address:		Work Phon	ie #:	
	N CASE OF EMERGENO			
Name of person to notify in an Emergency:		Relationship:		
Home Phone:	Cell Phone #:			
(Please giv	<b>INSURANCE INFORM</b> e you insurance card to the			
1. Primary Insurance Information:				
Subscriber Name:				
Date of Birth:	SS#:			
2. Secondary Insurance Information	(if applicable):			
Subscriber Name:				
Date of Birth:				



6	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:	
<b>Diabetes and Endocrinology Specialist Inc.</b> 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:	