Sun Coast Bariatrics
Discover the New You

SEMINAR DATE: _____

Last name: _____ First: _____ Middle: _____

Address: _____ City/State: _____ Zip Code: _____

Home Number: _____ Work: _____Cell:_____

Can we leave message? Home: Y / N Work: Y / N Cell: Y / N Email: Y / N

Male: ☐ Female: ☐ Email: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____Occupation: _____

Current Height: _____ft_____in **Current Weight: _____lbs**

Insurance Information:

Carrier Name: _____ Customer Svc Phone Number: _____

Policy Holder's Name: _____Policy DOB: _____

Policy Holder's Employer: _____

Relationship to Patient: _____ Group Number: _____

ID, Member, or Policy number: _____

I authorize Sun Coast Bariatrics to verify my insurance benefits. I authorize the release of insurance payments directly to Sun Coast Bariatrics and allow Sun Coast Bariatrics to release any information obtained in the course of my evaluation and treatment to permit processing of claims for insurance reimbursement. A photocopy of my signature is valid.

Signature of Patient: _____Date:____/____/____