

Seminar Location: _____ Date: _____ Dr.: _____
 Appt Location: _____ Date: _____ Dr.: _____ Time: _____

Patient Data

Patient Name: _____ D.O.B. _____
 Address: _____ Email: _____
 City/State: _____ Zip Code: _____
 1st: (Hm/Cell/Wk) 2nd: (Hm/Cell/Wk) Occupation: _____
 Phone: _____
 SSN: _____ Gender: _____ Marital Status: _____
 Primary Care Physician(PCP): _____ Dr. Phone #: _____
 Referring Dr.: _____ Dr. Phone #: _____

Insurance Information

Primary		Secondary
	Insurance Co Name	
	Policy or Certificate #	
	Group or Account #	
	Policy Holder's Name	
	Policy Holder's D.O.B. & SS#	
	Policy Holder's Employer	

Employer Information

Employer & Address: _____
 Employment: Full Time Part Time Self Employed Disabled Homemaker Student Retired Unemployed
 Ethnicity: African American Caucasian Native American or Alaska Native Asian
 Hispanic Native Hawaiian or Other Pacific Other

Permission for release of information: To the best of my knowledge, this information and the medical history that I report are correct. I authorize the physicians and staff of New Dimensions WLS, to release my demographic and medial information to insurance companies as necessary.