



BELAMEDICA

wellness • weightloss

Welcome to our office

Date _____

Please Print

Last Name _____ First Name _____ M.I. _____

Home Address _____

Date of Birth: ___/___/___ Age: _____ SS#: _____/_____/_____

Sex: M___F___ Marital Status: Single___Married___Divorced___Widowed___

Home Phone(_____) _____ Work(_____) _____

Cell Phone (_____) _____ E-mail _____

(Please circle best number to reach you during the day)

Employed By _____ Occupation _____

If patient is a minor, give parent's name _____

HAVE YOU EVER ATTENDED ONE OF OUR SEMINARS? YES _____ NO _____

How did you learn about us? Radio/Doctor/Patient/Friend/Internet/Other?

Name _____

Primary Care Physician:

Name: _____ Telephone:(_____) _____

Address: _____

Emergency Contact: _____ Telephone:(_____) _____

Primary Insurance

Name of Insurance: _____ ID Number _____

Billing Address:

Name of Policyholder _____ Phone:(_____) _____

Address: _____

ID Number: _____ Group# _____ SS# _____

Relationship to Client:Spouse___Parent___Other_____ Date of birth:___/___/___

Secondary Insurance

Name of Insurance: _____ ID Number _____

I hereby accept responsibility for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments and coinsurance at the time service is rendered. I certify that this information is true and correct to the best of my knowledge.

Signature of patient or guardian

Date