University of Nebraska Medical Center Bariatric Patient Registration Form

Name: _____ DOB: _____ Age: _____
(Last) (First) (Middle)

Address, City, State, Zip: _____ Phone: _____

Social Security # _____ Sex: _____ Marital Status: _____

Patient's Employer & Address: _____

Work Phone: _____ Is this a Workman's Compensation Claim? ___ Yes ___ No

Insurance Co. Name & Address: _____

Coinsurance Co. Name & Address: _____

Subscriber Name: _____ Group #: _____ ID#: _____

Name of Spouse, Parent or Guardian: _____

Address (If different from above): _____

Employer: _____
(Name) (Address, City, State, Zip) (Phone)

SSN# _____

PATIENT HISTORY: Family Physician: _____

Past Operations/Medical-Illnesses: _____

Allergies: _____ Current Medications: _____

_____

Current Problem: _____ Duration of Illness: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to _____, M.D. Any major medical or basic insurance benefits otherwise payable to me, but not to exceed the regular charges for such services. I understand that I am financially responsible for charges not covered by this authorization. I also authorize the release of such information as may be necessary to the proper authorities to determine benefits.

(Patient's or Authorized Signature) (Date) (Insured's Signature)