FAIRFIELD COUNTY BARIATRICS & SURGICAL SPECIALISTS, P.C.
PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

(Please give your driver's license or photo identification to the receptionist)

Patient Name: _____
(Last) (First) (Middle)

Is this your legal name (if not, please provide): _____

Maiden of Former Name (if applicable): _____

Marital Status (Circle One): Single Married Divorced Widowed

Date of Birth: _____ Social Security No. _____ Sex: M F

Street Address: _____

Town/City: _____ State: _____ Zip Code: _____

Phone Numbers: _____ _____ _____
(Home) (Cell) (Work)

Email Address: _____

Referral Source (Circle One): Physician Friend/Family Internet Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Co.: _____ ID Number: _____

Subscriber Name (if not self): _____ Date of Birth: _____

Relationship to Patient: _____ Social Security No.: _____

Secondary Insurance Co.: _____ ID Number: _____

PRIMARY CARE PHYSICIAN

Name of Physician: _____ Phone No.: _____

EMERGENCY CONTACT INFORMATION

In case of emergency please contact: _____

Relationship to Patient: _____ Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize Fairfield County Bariatrics & Surgical Specialists, P.C. to release any information required to process my claims.
I understand that is a referral is required from my primary care physician that I am responsible for obtaining the referral prior to receiving care and providing documentation of the referral at the time of service.
I am aware that I will be charged for any missed appointments that are not cancelled within 48 hours.
I have read and understand the office policies stated above and agree to accept responsibility as described.

_____ _____
Patient (Guardian) Signature Date