ULTIMATE
WEIGHT LOSS SOLUTIONS
Under Medical Supervision

PATIENT'S INFORMATION

Patient's Name_____ Date of Birth_____
First Middle Last
Address_____ Age_____

City_____ State_____ Zip_____

Phone #_____Cell Phone#_____ Email_____

Social Security #_____ Driver's License #_____

Employer_____ Address_____ City_____

Employer's Phone #_____ Date of Employment_____ Occupation_____

Martial Status: Single_____ Married_____ Divorced_____ Widowed_____

Spouses's Name_____ Date of Birth_____ Social Security #_____

Spouse's Employer_____ Address_____ City_____

Phone #_____ Date of Employment_____ Occupation_____

Were you referred by another doctor? ❑ Yes ❑ No Doctor's Name_____

How did you hear about us? ❑ Online (Website Name)_____ ❑ Magazine ❑ Brochure
❑ Friend (Name) _____ ❑ Other_____

INSURANCE INFORMATION

Insurance Name_____ Policy #_____ Effective Date_____

Insurance Address _____City_____ State_____ Zip_____

Name of policy holder_____ Date of Birth_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Employer (If not listed above)_____ Phone #_____

Insurance Coverage through work: Yes_____ No_____ Date Employment_____

Relationship to Patient_____

In case of emergency please contact: (Relative)_____ Phone #_____

(Friend)_____ Phone #_____

Assignment and Authorization: I here by authorize Ultimate Weight Loss Solutions to release any and all medical information to my insurance carrier for purposes of claims, administration and evaluation, utilization and review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization and understand it. I hereby assign to Ultimate Weight Loss Solutions; all money to which I am entitled for Medical expense relative to this service rendered to me, but not to exceed my indebtedness to said physician/surgeon. I understand I am financially responsible to aid doctor for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection and/or court cost and legal fees should this be required.

Signature_____ **Date**_____