HARTSDALE MEDSPA
WEIGHT LOSS & LASER BODY CONTOURING

BARIATRIC PATIENT INFORMATION FORM

Patient Name (Last, First) ____________________

Address ____________________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell Phone ____________

Email ____________________

Date of birth ____________ Age ____________ Sex ____________

Country of birth ____________ Country of parent's birth ____________

Social Security # ____________ Drivers License State and # ____________

Education (circle highest level achieved)

Elementary High School/Technical 2 yr College 4yr College Graduate School

Employment Information

Employer Name ____________ Occupation ____________

Employer Address ____________________

City ____________ State ____________ Zip ____________

Work Phone ____________ Ext. ____________

Emergency Information

Name ____________ Relation ____________ Phone ____________

Patient Spouse ____________ Phone ____________

Family Physician ____________ Phone ____________

Referred by ____________________

Financial Policy

This is to inform you of our billing requirements and financial policy. Please be advised that payment for all services will be due at the time services are rendered.

I understand that this may NOT be a covered benefit by my insurance plan and that I am financially responsible for all charges presented to me, which are to be PAID IN FULL at the time services are provided (cost of diet programs vary depending on each individuals need). I agree that should my account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, including but not limited to attorneys and court expenses. I have read and understand all of the above and agree to these statements.

Patient's Signature ____________ Date ____________