Northside Bariatric Surgery Center
960 Johnson Ferry Rd, Ste 228
Atlanta, GA 30342

-Patient Information-

Name:____________________, ________________________ __________________Soc. Sec. #:______________
Last First Middle

Address:____ Apt:____________________

City: ___________________________State:______________ Zip: ________ Home Phone:____________________

Cell Phone: ______________________ Sex: Male / Female Age:__________ Birth date:______________________

Marital Status: ____________________Employer: ____`_____________________________Work Phone:____________

Emergency Contact:____Phone: __________________

Patient E-Mail Address:____

Who may we thank for referring you?____

-Primary Insurance-

Name of Insurance:____

ID #: ___________________________ Group #:________________________ Phone: #_______________________

Name of insured/card holder: ___________________________, ________________ ______________________
Last First Middle

Do you have a flex spending account?____

Relationship to patient: ____Birth date: ___________________

Soc. Sec. #: _____________________ Address:____ Apt:________

City: ___________________________State:______________ Zip Code:__________ Phone #:________________

-Additional Insurance-

Is patient covered by additional insurance? Yes / No

Name of insurance: ____

ID #: ___________________________ Group #:________________________ Phone #:_______________________

Name of insured/cardholder: ___________________________, ______________________ ________________
Last First Middle

Relationship to patient: ____Birth date:___________________

Soc. Sec. #: _____________________ Address:____ Apt: ________

City: ___________________________State:______________ Zip Code:__________ Phone #:________________

-Assignment and Release-

I authorize Northside Bariatric Surgery Center to release, to my insurance company, information required in the course of my treatment for processing this or a related medical claim. I hereby authorize direct payment of any benefits for these medical services. I understand I am financially responsible for payment of all services rendered regardless of insurance coverage.

Patient Signature:____Date:________________________________