

PATIENT REGISTRATION FORM MIKEL SODOMA BODYWISE TODAY'S DATE _____

PATIENT NAME _____ RESPONSIBLE PARTY _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

YEAR ROUND RESIDENT SEASONAL RESIDENT ALTERNATE ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

GENDER _____ RACE _____ LANGUAGE SPOKEN AT HOME _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMAIL ADDRESS _____ MARITAL STATUS _____ LEFT OR RIGHT HANDED

PRIMARY CARE PHYSICIAN NAME/PHONE _____

PHARMACY/CROSSTREETS/PHONE _____

PRIMARY INSURANCE

SECONDARY INSURANCE

INSURANCE CO. _____ INSURANCE CO. _____

CLAIMS ADDRESS _____ CLAIMS ADDRESS _____

INSURED'S NAME _____ INSURED'S NAME _____

RELATIONSHIP _____ RELATIONSHIP _____

POLICY # _____ POLICY # _____

GROUP # _____ GROUP # _____

INSURED DOB _____ INSURED DOB _____

INSURED GENDER _____ INSURED GENDER _____

SPECIALIST COPAY _____ SPECIALIST COPAY _____

HOW DID YOU HEAR ABOUT THIS PRACTICE? NEWSPAPER AD INTERNET AD PCP REFERRED FRIEND YELLOW PAGES

OTHER: _____

I AM INTERESTED IN RECEIVING INFORMATION ABOUT THE FOLLOWING ISSUES (CIRCLE ALL THAT APPLY)

WEIGHT LOSS PERMANENT STERILIZATION LIGHTER MENSTRUAL PERIODS HORMONE BALANCING

CONTRACEPTION BIO-IDENTICAL HORMONE REPLACEMENT AWAKE LIPOSUCTION ESSURE ABLATION

Assignment and Release: 1. I hereby assign my insurance benefits to be paid directly to the physician; or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make out the check to me and the rendering physician. 2. I also authorize the physician to deposit checks received on the patient's account when made out to the patient. 3. I also authorize the physician to release any information required to process claims or required in the course of my exam and treatment. 4. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. 5. I authorize my rendering physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature _____ Date _____