

Consult: _____ Psych Eval: _____ Ins./SP: _____ Program Fee: _____

CENTER FOR METABOLIC AND BARIATRIC SURGERY FAST TRACK METABOLIC WEIGHT LOSS CENTER

Initial application for consult with Dr. Trace Curry

Name: _____ Birthdate: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Social Sec #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

If we need to contact you, which phone number should we call first? _____

Which phone number may we leave a message on? _____

Is there a phone number we should not call? _____

Male Female Marital Status: Married Single Divorced Widowed Race: _____

Employer _____ Occupation: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Employment status: Full time Part-time Self employed Homemaker Student Retired

Disabled Unemployed Not specified

Primary Insurance _____ Policy # _____ Group # _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber name: _____ Subscriber's Date of Birth: _____

Is this a group policy through an employer? Yes () No () Employer: _____

Is surgical weight loss a covered benefit under your plan? Yes () No () Unsure ()

Secondary Insurance _____ Policy # _____ Group # _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Is this a group policy through an employer? Yes () No () Employer: _____

Is surgical weight loss a covered benefit under your plan? Yes () No () Unsure ()

Family Doctor – Very important we need this filled out completely!

Name: _____ Phone: _____

Address: _____ Fax: _____

Physician Specialists (Heart, Lungs, Kidney, etc.)

Name: _____ Phone: _____

Address: _____ Fax: _____

THE CENTER FOR METABOLIC AND BARIATRIC SURGERY

AUTHORIZATION TO RELEASE PRIVATE HEALTH CARE INFORMATION TO SELECTED PERSONS

I, _____, authorize the following listed persons below to communicate with The Center For Metabolic and Bariatric Surgery in reference to the allowed information.

Should I choose to retract or change any or all of this information I will contact this office in writing.

- | | | | |
|----|-------|--------------------|--------------------|
| 1. | _____ | Relationship _____ | Phone number _____ |
| 2. | _____ | Relationship _____ | Phone number _____ |
| 3. | _____ | Relationship _____ | Phone number _____ |
| 4. | _____ | Relationship _____ | Phone number _____ |

Patient Name Date

Patient or Patient Representative Signature Date

I have answered the above questions on page one and page two of this document truthfully to the best of my ability.

I give my permission for The Center of Metabolic and Bariatric Surgery, LLC/Trace W. Curry, MD/JourneyLite to leave messages regarding confirmation, change or cancellation of my office appointment and or financial information, on an answering machine, with a family member or any adult person answering my telephone. I further give permission to release any medical information, dictation, lab results or billing information about me to any specialist, physician, insurance company, health care agency, persons I identify as authorized, or to myself.

Patient's Signature Date

DO NOT WRITE BELOW THIS LINE

I have personally reviewed the patient's medical/surgical history, medications, family history, and review of systems.

Provider Date