WITTGROVE BARIATRIC *CENTER*

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Medical Director

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Patient Information: **Fax: (858) 554.1771**

Last name, first, middle initial			Date of Birth	Sex	Martial Status M D S W
Street Address			Home Phone		Email Address
City	State	Zip code	Work Phone		Telefax Number
Employer's Name			Driver's License Number and State in Which Issued		
Employer's Street Address			Social Security number		
City	State	Zip code	Occupation		
Emergency Contact:		Relationship	Religious Preference(statistical purpose only)		Race (statistical purpose only)
Street Address			Home Phone		Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? Lecture Friend Internet
(Circle one and complete information) **Date: _____ Name: _____**

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

By checking this box ☐ I authorize "the program" to contact me by mail, phone or e-mail.

Signature: _____Date: _____

For Office Use Only:
Date of Physical: _____ Date of Surgery: _____ Auth #:_____
P:\WBC-La Jolla\Insurance\Health History Questionnaire~Face Sheet wbc.doc