The Bariatric & Metabolic
WEIGHT LOSS CENTER
A subsidiary of Piedmont Family Practice

Patient Information

Last: ______________________ First: ________________ MI: ___ Previous: _________
SSN: ______________________ DOB: __________________ Sex: M or F

Billing Address

Street____ Apt.#___________
City____ State__________ Zip___________
Primary Care Physician__________________________________ Marital Status__________
Home Phone____
Work Phone____
Cell Phone____
Email____

Preferred method of contact Home Work Cell **(Please circle all that apply)**
May we leave a message? Yes No
May we contact you by email? Yes No

Emergency contacts

Name: ________________________ Relation: ______________ Phone: ________________
Name: ________________________ Relation: ______________ Phone: ________________
Insurance Information (please provide a copy of your card at check-in)

Primary Insurance

Name of Insurance ____
Policy Holder's name ____________________________________ D.O. B________________
Subscriber's ID ____________________________________ Group #____________________
Relation to Policy Holder ______________________

Secondary Insurance (if applicable):

Name of policy holder____________________________
D.O.B.______________ Subscriber's ID __________________________________
Relation to Policy Holder__________________________