**PATIENT INFORMATION FORM**

Patient Name: (Last) (First) (MI)

Name you prefer to be called:

Address:

City: State: Zip:

Home Phone: Cell Phone:

Birthdate: Age:

Email Address: Social Security Number:

Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer Choose not to disclose Other gender category not listed

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

**Employment Information**

Employer: Occupation:

Employer Address:

City: State: Zip:

Work Phone: Ext:

**Emergency Contact**

Name: Relationship: Phone:

Primary Care Provider: Phone:

**Pharmacy and Labs**

Preferred Pharmacy:

Address: Phone:

Preferred Lab:

Address: Phone:

**Insurance**

Primary Insurance:

Secondary Insurance:

*Please present your insurance card to staff at the front desk.*

**Financial Policy**

Thank you for selecting Heal Medical Weight Loss for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

Please be advised that payment for all services will be due at the time services are rendered unless prior arrangements have been made. For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS, CHECKS, OR CASH).

Please be advised that payment for all services will be due at the time of services rendered, unless prior arrangements have been made. We accept some forms of insurance. Please discuss your insurance coverage with a staff member.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney’s fees, and court costs.

I have read and understand all of the above and have agreed to these statements.

Signature Date

Printed Name