

WEIGHT MANAGEMENT CENTER

A Program of The Jewish Hospitals of Cincinnati

6350 E. Galbraith Road • Cincinnati, Ohio 45236 • (513) 686-6820 Fax (513) 686-6819

U-Turn Required

Date _____

Name _____ Maiden Name _____

Address _____

City _____ State _____ Zip _____

SS # _____ - _____ - _____ Date of Birth _____ Age _____

Gender (circle one) M / F Marital status (circle one) married / divorced / widowed / separated / never married

Race (circle one) White / African American / Hispanic / American Indian or Alaskan native / Asian / Pacific Islander / Other

Please indicate number you can be reached at during the day, or message left

Home phone number _____ Work _____

Pager _____ Cell _____

Employer _____

Work address _____

City _____ State _____ zip _____

Occupation _____

Spouse's name _____ spouse date of birth _____

Spouse SS# _____ - _____ - _____ work phone _____

Spouse's employer _____

Work address _____

Referring physician _____ Phone # _____ Fax # _____

Address _____

Family physician _____ Phone # _____ Fax # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity. I understand that I am financially responsible for any balance not covered by the insurance carrier(s). I also request that payment of benefits from my policy _____ (Medigap / Other) be paid directly to the billing entity until otherwise notified.

Signature

A Way To Manage Weight That Is A Way Of Life