

## REAL Weight Loss Solutions At St. John Detroit Riverview

### Patient Registration

<b>Patient's Name: Last</b>			<b>First</b>	<b>Middle</b>	<b>Social Security #</b>		<b>Marital Status</b> Single    Married Partner    Divorced Widowed	
<b>Birth Date</b>	<b>Age</b>	<b>Male</b>	<b>Female</b>	<b>Email Address</b>				
<b>Street Address</b>						<b>City</b>		
<b>P.O. Box</b>			<b>City</b>		<b>State</b>	<b>Zip Code</b>	<b>Home Phone #</b>	
<b>Cell Phone #</b>		<b>Occupation</b>		<b>Employer</b>			<b>Work Phone #</b>	
<b>Primary Care Physician</b>				<b>Primary Care Physician Address</b>				
<b>Primary Care Physician Phone #</b>			<b>Referred By (Physician Name)</b>			<b>Referring Physician Phone #</b>		
<b>Referring Physician Address</b>						<b>Height</b> Ft.    In.	<b>Current Weight</b>	
<b>How did you learn about REAL Weight Loss Solutions at St. John Detroit Riverview Hospital?</b> Friend/ Relative    PCP    Website    Radio    Print    Other Physician    Other: _____								

### Insurance Information

<b>Primary Insurance Name:</b>				<b>Subscriber Name:</b>			
<b>Subscriber SS#:</b>		<b>Subscriber D.O.B.</b>		<b>Contract Number</b>		<b>Group Number</b>	
<b>Patient's Relationship To Subscriber:</b>				Self	Spouse	Child	Other:
<b>Secondary Insurance Name:</b>				<b>Subscriber Name:</b>			
<b>Subscriber SS#</b>		<b>Subscriber D.O.B.</b>		<b>Contract Number</b>		<b>Group Number</b>	
<b>Patient's Relationship To Subscriber:</b>				Self	Spouse	Child	Other:

### Emergency Contact

<b>Name of Friend or Relative Not Living at same Address</b>	<b>Relationship to Patient</b>	<b>Home Phone</b>

The above information is true to my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am responsible for any balance. I authorize REAL Weight Loss Solutions at St. John Detroit Riverview Hospital or insurance company to release any information required to process my claims.

<b>X</b> _____	<b>Date:</b> _____
<b>Patient/ Guardian Signature</b>	