General Surgery
This form must be completed in full

Patient Last Name		Patient First Name	Middle Initial	Male______ Female_____
Date of Birth	Patient's SS#	Home Number	Work Number	Cell Number

Mailing Address	Email Address

Home Address If Different		
Referring Physician (**Dr's first and last name**)	Address	Phone Number
Primary Care Physician (**Dr's first and last name**)	Address	Phone Number
Patient's Employer	Phone Number	
Spouse's Name	Spouse's Employer	Spouse's work Numbe
Emergency Contact	Relationship	Phone Numbe
Guarantor (Person responsible for bill) Address of Guarantor	Date of Birth	Social Security Numbe
Primary Insurance Date of Birth of Policy Holder Policy Holder Employer	Name of Policy Holder ID# on Policy	SS# of Policy Holder Group #
Secondary Insurance Date of Birth of Policy Holder Policy Holder Employer	Name of Policy Holder ID# on Policy	SS# of Policy Holder Group #
Workman's Compensation? (Circle One) Yes No		

Full payment is due at the time of service. I agree to be responsible for my expenses. I authorize my insurance company, attorney or any other parties to pay Bariatric Specialists of North Carolina, PA directly and provide any information regarding payment of my medical charges. I accept responsibility for any balance due and any items not covered by my insurance company. I authorize the physician to administer medical care as is necessary.

Signature: ____ Date ____________________