Beaumont

Bariatric & General Surgery - Dr. Kole
44199 Dequindre Rd.
Troy, MI 48085
Area C, Suite 315, Troy-POB

Patient Information Date: ________________

Name: ____ Birth Date: _____/_____/_____

Social Security No: _______________________

Address: _____________________________ City: _________________ State: ______ Zip: ________

Home Phone: ________________________ Cell Phone: ____________________

Sex: Male Female

How did you hear about us? Friend / Family Beaumont Website Newspaper Ad Beaumont Referral Beaumont E.R.

Primary Insurance: (Please present Insurance Card and Driver's License (or proper picture ID) at the time of your visit, if you cannot provide proper identification, your appointment may be delayed or rescheduled)

Insurance Name: ______________________________ Effective Date: ___________________

ID/Contract No: __________________________ Group No: ______________________

Policy Holder: ____________________________ Relationship to Patient: __________________

Subscriber Birth Date: _____/_____/_____ Employer: ___________________________________

Secondary Insurance:

Insurance Name: ______________________________ Effective Date: ___________________

ID/Contract No: __________________________ Group No: ______________________

Policy Holder: ____________________________ Relationship to Patient: __________________

Subscriber Birth Date: _____/_____/_____ Employer: ___________________________________

Have you or anyone in your immediate family traveled outside of the United States in the past 30 days? Yes____ No____

Emergency Contact: Name: ___________________________________Phone: _________________________

Relationship: ___________________

I understand that it is my responsibility as a patient to know my own insurance. I understand that there may be charges that my insurance plan will not pay, and I agree to pay Beaumont Acute Care Surgery for any and all services rendered in its entirety.

____ ____________________
(Patient Signature) (Today's date)

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Patient Name: ____ Date of Birth: _____/_____/_____

List of current medications: (If you have a current list, please present it to the office and you may skip this section and proceed to below Allergies)

Name	Strength	Directions
1.		
2.		
3.		
4.		
5.		
6.		

List all allergies:

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

*Please attach a separate sheet if necessary for any additional information

If applicable:
Have you had Bariatric Surgery in the Past? _______ If so, when?_________, where?_________________________
Who was your Bariatric Surgeon?_________________________________

What brings you to the office today?____
____
____

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Release of Patient Information

Do you wish to authorize the release of your medical information to another individual(s), such as spouse, parent, child, guardian, partner, etc? Yes No

_______________________________________ ___________________________
Name of individual to which information may be released **Relationship to Patient**

_______________________________________ ___________________________
Name of individual to which information may be released **Relationship to Patient**

_______________________________________ ___________________________
Name of individual to which information may be released **Relationship to Patient**

____ ___________________
Signature of Patient, Parent, Guardian or Personal Representative **Date**

Advance Directive

Do you have an Advance Directive? Yes No

If yes, please provide us with a copy for your electronic medical record.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the named insurance and are assigned directly to Dr. Kole for all insurance benefits. I understand that I am financially responsible for all charges for services rendered for my appointments whether or not paid by insurance. I authorize the use of my signature on all submissions. Dr. Kole and their agents may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related service.

____
Print Name of Patient, Parent, Guardian or Personal Representative

____ ___________________
Signature of Patient, Parent, Guardian or Personal Representative **Date**

PATEINTS MUST BRING COMPLETED FORM WITH THEM TO THEIR CONSULTATION APPOINTMENT OR BE PRESENT TO SIGN

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