quantum
medical weight loss

Patient Information

Date:			
First Name:	**MI:**		**Last Name:**
Address:		City/State/Zip:	
Date of Birth:	Age:		Gender: Male ☐ Female ☐
Social Security #:		Marital Status: S ☐ M ☐ D ☐ W ☐	
Home Phone:		Cell Phone:	
Patient Employer:		Work phone: Ext:	
Occupation:			
Email:		Ok to communicate by email? Yes ☐ No ☐	
Spouse/Guardian:		Spouse Guardian employer:	

Primary Insurance:
Insurance Co-pay (please pay today, see reverse for information):
Subscriber Name:
Insurance ID #:
Group #:
Secondary Insurance:
Subscriber Name:
Insurance ID #:
Group #:

Referring Healthcare Provider:
Primary Care Physician:

Please list the name of someone who we may contact in case of an emergency		
Name:	Relationship:	Phone:

Signature: _____ Date: _____

Please read and sign the second page of this form.
Thank you!

We will bill your insurance for you, providing that you supply Quantum Medical Weight Loss **with complete and current billing information.** Any balance after insurance has paid is your responsibility and is due and payable upon receipt of our statement. Insurance co-pays are due at the time of service.

If you do not come to your appointment, or call to cancel your appointment at least 24 hours in advance there will be a $50 no-show/cancellation fee.

Please contact your pharmacy directly for prescription refills, and allow 48-72 business hours for processing.

Please carefully read the following statement, then sign and date it:
I have read and I understand the above information. I understand that a **$25.00 fee** will be added to my account in the event of a returned check due to insufficient funds. I authorize my insurance benefits to be paid directly to Sound Sleep Health. I also authorize the release of any information required by my insurance carrier to process medical claims.

Signature: _____ Date: _____