Job: CL3458
CWM-120
1st proof: 11/2/07
Ink: Black
Paper: 20# White

Carolinas Weight Management
& Wellness Center

Diagnosis/Complaint ________________ **Referring Physician** ________________

PATIENT INFORMATION

Referring Physician Phone ________________

Last Name		First Name		Middle or Maiden	
Social Security	Sex	DOB	Age	Place of Birth	
Home Address	Apt.	City		State	Zip
Home Phone	Cell Phone			Email Address	
Name of Employer	Work Phone		Job Title		Location
Full Time/ Part Time / Disabled	Marital Status		Race		

Guarantor (policyholder of the primary insurance)

Last Name		First Name			Middle or Maiden	
Social Security		Sex	DOB	Age	Place of Birth	
Home Address		Apt.	City		State	Zip
Home Phone	Work Phone	Name of Employer & Address				
Full Time/ Part Time / Disabled		Job Status		Race		Marital Status

Emergency Contact Information

Emergency Contact Name		Relationship to Patient
Mailing Address	Home Phone	Work Phone

Insurance Information

Is patient covered by medicare ________
Black Lung Benefit ________
Is this condition due to accident ________
DVA authorized and agreed ________
Date condition started ________

Place of accident ________
Time of accident ________ am / pm
Type of accident: work / auto
Date of accident ________
Service paid by gov't program ________

Is Spouse Retired ________
Date of Retirement ________
Is Patient Retired ________
Date of Retirement ________

Primary		**Secondary**	
Insurance Co. Name		Insurance Co. Name	
Address		Address	
City, County, State, Zip		City, County, State, Zip	
Insured's Last Name	First	Insured's Last Name	First
Group Number		Group Number	
Policy Number or SS#		Policy Number or SS#	
Relationship to Insured		Relationship to Insured	
Employer	Phone	Employer	Phone

ICD-9 ________ A # ________ H # ________