Russell S. Gornichec, MD, PC, FACS
General & Bariatric Surgery
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Hot Springs AR 71901
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WeightLossCenterAR.com

Patient Information

Last name, first, middle initial	Date of Birth	Sex	Marital Status Married Divorced Single Widowed
Street Address	Home Phone		Cell Phone
City, State, Zip Code	Work Phone		Fax Number
Email Address	Social Security Number		
Employer's Name	Drivers License Number		State in Which Issued
Employer's Street Address			Occupation
City, State, Zip Code			
Emergency Contact Relationship	Religious Preference (statistical purposes only)		Race (statistical purposes only)
Street Address	Home Phone		Work Phone
Next of Kin	Home Phone		Work Phone

Insurance Information

Primary Insurance		Secondary Insurance	
Address		Address	
Customer Service Phone Number		Customer Service Phone Number	
Policy or ID Number		Policy or ID Number	
Subscribers Name		Subscribers Name	
Relationship to Patient		Relationship to Patient	
Subscribers Employer, Address, Telephone Number		Subscribers Employer, Address, Telephone Number	
Subscribers Date Of Birth	Subscribers Social Security No.	Subscribers Date Of Birth	Subscribers Social Security No.

How did you hear about us? Lecture _______ Friend _______ Internet _______
Date: ____________________ Name: ____

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as the original.

By checking this box I authorize "the program" to contact me by mail, phone or email.

Signature: ____ Date: ______________________