St. Luke's Des Peres Hospital

myNewSelf

PATIENT INFORMATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Legal Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Maiden Name:	Birth date: / /	Age:	Sex: ❑ M ❑F
Street address:	Social Security Number:	Home phone number: ( )	Cell phone number: ( )
P.O. Box:	City:	State:	ZIP Code:

Employment Status: ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Homemaker ❑ Student ❑ Retired ❑ Disabled ❑ Unemployed ❑ Other

Occupation:	Employer:	Employer phone number: ( )

Employers Address:

Is Patient the Responsible Party? ❑ Yes ❑ No	EMAIL ADDRESS:

Spouse's Legal Name	Birth date: / /	Phone Number:

Employment Status: ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Homemaker ❑ Student ❑ Retired ❑ Disabled ❑ Unemployed ❑ Other

Occupation:	Employer:	Employer phone number: ( )

Employers Address:

INSURANCE INFORMATION

Primary Insurance Company:		Phone: ( )
ID Number:	Group Number:	Name on Policy:
Secondary Insurance Company:		Phone: ( )
ID Number:	Group Number	Name on Policy:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone : ( )

I authorize MyNewSelf Bariatrics at St. Luke's Des Peres Hospital to release to the surgeon of my choice, my insurance company or any third party, any information, including diagnosis and records of such treatment, as necessary to determine my eligibility for any procedure, my liability for payment and to obtain reimbursement. I authorize MyNewSelf to release any information acquired in the course of my examination or treatment to my insurance company in order to file a claim. I understand that if my account is not paid when due, I will be responsible for all costs incurred in the collection process of my account. I further understand that my account will be reported to a credit bureau. MyNewSelf does no deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs.

*Patient/responsible party signature*_____ *Date*_____