GRIFFIN BARIATRICS
EMPOWERING HEALTHIER LIVING

We understand that you are anxious to make your first appointment. As a courtesy, we will verify your insurance benefits. Unfortunately, we cannot be responsible if incorrect information is given to us. **Please be aware that as a patient, you must take full responsibility for your own insurance.** This means you will have to, at some point, verify your own benefits. It is often easier for patients to call their Human Resource department for a quicker and more accurate overview.

***Please PRINT clearly (this is VERY important)**

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Policy-Holder's Employer: _____

Insurance Company's Name: _____

Insurance Policy/ID Number: _____

Insurance Phone Number (on back of card):_____

Name of Primary Care Physician: _____

How did you hear about us? _____

Once we have obtained benefit information, we will contact you within 48 hours.

Phone: _____ Email: _____

If you are not available, may we leave a message? _____

If there is someone you would like us to speak with on your behalf, then please provide their name and phone number here:_____

****Si hay alguna persona que puede hablar por usted, si no entiende ingles por favor escribe el nombre y número de teléfono aqui:_____**

If you do not have your insurance information, you may email us at: Srodriguez@griffinhealth.org or fax this form to: (203) 225-7744.

Patient Signature: _____ Date: _____

By signing and completing this form, you are confirming that you have attended a "New Patient Free Educational and Informational Seminar", and have been told about the risks and complications that can occur during and after bariatric surgery, the statistical results that occur after weight-loss surgery, and the nutritional expectations that will be necessary for you to follow.

Office Use Only: Date, Location of Seminar & MD: _____; _____, _____
Benefit: □ Yes □ No Name of Insurance Rep:_____ Date Called (Ins):_____
Deduct:_____ CoPay:_____% Split:_____ Max out of Pocket:_____ OoN Cov: Y/N
Date Called (Pt):_____ Voice Mail_____ Appt Set (Date):_____