North Ottawa Community Health System

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ DOB __/__/__

Gender: (F) (M) Marital Status: (S) (M) (D) (W) (O)

Race: _____ Primary Language: _____ Ethnicity: ___ Non Hispanic ___ Hispanic

Drivers License # _____ Religion _____

Address: _____ Social Security # _____

City, State, Zip _____ Home Phone _____

Email _____ Cell Phone _____

Employer _____ Work Phone _____

Where do you prefer to be called? ❑ Work ❑ Home ❑ Cell

May we leave a message? ❑ Yes ❑ No May we email? ❑ Yes ❑ No

IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Preferred Phone #: _____ DOB: _____

Program Interest ☐ Bariatric Surgery ☐ Medical Weight Loss ☐ Weight Loss Medication Management

Primary Care Physician

Physician's First Name: _____ Physician's Last Name: _____ ☐ MD ☐ DO

Physician's Address: _____

City, State, Zip: _____

Physicians PHONE/Fax Number: _____

Were you referred to us by this doctor? ☐ YES ☐ NO

Did a NOCHS patient refer you here? ☐ YES _____ ☐ NO _____

(Patient's Name) (Other Referral Source)

Pharmacy: _____ **Phone:** _____

Primary Insurance: _____

Subscriber: _____ Subscriber DOB: _____ Relationship to Insured: _____

Subscriber Employer: _____ Member ID: _____ Group Number: _____

Co-Pay: _____ Person Responsible for Payment: _____

Secondary Insurance: _____

Subscriber: _____ Subscriber DOB: _____ Relationship to Insured: _____

Subscriber Employer: _____ Member ID: _____ Group Number: _____

Co-Pay: _____ Person Responsible for Payment: _____

It is your responsibility to pay any co-pays, deductibles, co-insurance or any other non-covered services at the time of service for plans with which we participate. As a courtesy to you, we will bill all insurance companies whether or not we participate, however, you will be held responsible for the charges.