Total Weight Loss Center

Registration Form

Patient Information

Seminar Date: _____/_____/_____

First Name: _____ MI: _____ Last: _____

Date of Birth: ___ /___/___ Gender: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W Spouse Name: _____

Race: ☐White ☐Black ☐Hispanic ☐Native American ☐Asian/Pacific Islander ☐Other

Ethnicity: ☐Hispanic ☐Non-Hispanic Preferred Language: _____

Height: _____ Weight: _____ lbs. Medical Condition: _____

SSN: _____ Primary Care Physician: _____

Contact Information

Street: _____ City/State/Zip: _____

Primary Phone: (_____)_____-_____
☐Detailed message is fine.

Secondary Phone: (_____)_____-_____
☐Detailed message is fine.

Email: _____ Work Phone: (_____)_____-_____

Preferred method to contact me: ☐Primary Contact ☐Secondary Contact ☐Email ☐Work Phone

In case of emergency, notify: _____ Relationship to patient: _____

Phone: (_____)_____-_____ Alternate phone (_____)_____-_____

Insurance Information

Primary Insurance: _____

Member ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

Group#/Employer Name: _____

Insurance Phone: _____

Secondary Insurance: _____

Member ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

Group#/Employer Name: _____

Insurance Phone: _____

☐ **I have been a patient at NKCH.**

☐ **I have had previous bariatric surgery.**

I am considering having surgery at North Kansas City Hospital and would be willing to make an appointment with the surgeon to discuss my options.

☐Please contact me about making an appointment. ☐I am not interested at this time.

Signature: _____ Date: _____ / _____ / _____

If you have any questions or need assistance, call our insurance coordinators at 816.691.5048.

Print

Save the completed form, attach and email it to Office@MeritasHealth.com.
Or, click **Print** to print the competed form and bring it to your next appointment.

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