# Doctors' Weight Management Program
# Patient Application

**Please Print:**

Name: _____
Last First Middle

Street Address: _____

City, State, ZIP: _____

Home Phone: (___) _____

Work Phone: (___) _____

Cell Phone: (___) _____ Text Ok: Y N

Phone number okay for private message: (Circle one)
Home / Work / Cell ☐

Email: _____

Sex: Male/Female (circle) Age: _____

Date of Birth: _____
month / day / year

How did you hear about the program?

_____

Occupation: _____

Employer: _____

Emergency contact: _____

Relationship: _____

Phone: (___) _____

**Primary Care Provider:**

Name: _____

Sansum Provider: Yes No

If not a Sansum Provider, please provide:

Address: _____

City/State/ZIP: _____

Phone: (___) _____

Fax: (___) _____

**Other Provider: (If regularly seen.)**

Name: _____

Sansum Provider: Yes No

If not a Sansum Provider, please provide:

Specialty: _____

Address: _____

City/State/ZIP: _____

Phone: (___) _____

Fax: (___) _____

**Insurance Information**:

Insurance Carrier: _____

Policy Number: _____

PPO: ☐ HMO: ☐

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For Staff Use:

Diet _____ Pref Class Day _____ Foundations Date _____ Class Start Date _____ eConf _____

OR _____ REF____ CBC_____ CMP_____ LIP_____ TSH_____ EKG _____ GLUC_____

Staff _____ MyChart Status_____ PDE _____ Med List Rec'd _____ Meds in Chart _____