Baum Weight Loss Program
560 W. Grangeville Blvd. Suite- A
Hanford, CA 93230
P) 559-408-5533 F) 800-827-1977

Patient Registration Form

Please Print

Patient Name First:_____ MI: ____ Last:_____
Gender Identity: _____. Sexual Orientation: _____
Date of Birth: ___ / ___ / ___ Social Security: _____
Cell Phone #_____ E-Mail: _____
Home Phone# :_____ Work Phone#: _____

Address: _____
City: _____STATE: _____ Zip _____

Mailing Address: _____
City:_____ STATE: _____ Zip:_____

Marital Status: _____ Spouse Name: _____ Phone#:_____

Any Known Drug Allergies? Y / N If Yes, What? _____
Any Food Allergies? Y/N If Yes, What?_____
Do you have a Latex Allergy? Y / N

Ethnicity / Race: _____
Mothers Maiden Name: _____
Primary Language Spoken: _____
Preferred Method of Communication: E-mail / Home Phone / Mail / Cell Phone / Work Phone
Preferred Pharmacy_____

Insurance Information

PRIMARY Insurance Carrier: _____Phone: _____
ID#_____Group#_____
Name of Policy Holder: _____DOB: _____/_____/_____
SS# of Policy Holder (if applicable): _____
Policy Holder Address: _____ Phone #: _____
Policy Holder Employer: _____
Employers Insurance Plan? Y / N. Relationship to patient: Self / Sponsor / Child

SECONDARY Insurance Carrier: _____Phone: _____
ID#_____Group#_____
Name on Policy Holder: _____DOB: _____/_____/_____
SS# of Policy Holder (if applicable): _____
Policy Holder Address: _____ Phone #: _____
Policy Holder Employer: _____
Employers Insurance Plan? Y / N. Relationship to patient: Self / Sponsor / Child

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Is your visit today due to a WORKERS COMPENSATION CASE or AUTO ACCIDENT? Y / N
If So Date of Injury: _____Employer Name: _____
Employer Address: _____
Employer Phone #_____

Name of Your Previous Physician: _____
Phone #: _____
Address: _____

Emergency Contact Info

Name: _____
Relationship to Patient: _____
Emergency contact Cell Phone # _____Work# _____
Address: _____