ROLLER
WEIGHT LOSS &
ADVANCED SURGERY

1695 E Rainforest Dr. Ste. 2
Fayetteville, AR 72703
Ph 479-445-6460 · Fx 479-445-6719

12112 Hwy 71 South
Fort Smith, AR72716
Ph 479-434-6222 · Fx 479-434-6354

3311 E 46th Street
Tulsa, OK 74135
Ph 918-970-6366 · Fx 918-970-6369

www.rollerweightloss.com

REGISTRATION FORM

WHAT ARE YOU BEING SEEN FOR TODAY ❑ Weight Loss Surgery ❑ General Surgery

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City, State, Zip

Social Security No:	Home Phone ( )	Work phone no.: ( )	Cell phone no.: ( )

Ethnicity (circle one) White Hispanic African American Other Decline to specify

Occupation:	Employer:	Employer phone no.: ( )
Primary Care Physician:	Primary Care Address:	Primary Care Phone no.: ( )

Email Address:	Would you like access to our patient portal? (Circle one) Yes No

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Roller Weight Loss and Advanced Surgery or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date