Kristine D. LaRocca, D.O.
LaRocca Medical Weight Loss
Office: (302) 468-6220 | Fax: (877) 370-4281
20 Montchanin Rd., Suite 125, Greenville, DE 19807
kristine@doctorlarocca.com | DoctorLaRocca.com

PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____

Email Address: _____

Sex: Male Female Transgender (F to M) Transgender (M to F) Gender queer
Choose not to disclose Other:_____

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

Employment Information

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Ext: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy and Labs

Preferred Pharmacy: _____

Address: _____ Phone: _____

Preferred Lab: _____

Address: _____ Phone: _____

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Insurance

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Please present your insurance card at time of visit.

Financial Policy

Thank you for selecting LaRocca Medical Weight Loss for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard, American Express, and Checks.

In some cases, insurance policies will reimburse you for services rendered at LaRocca Medical Weight Loss, but this is not guaranteed. Please discuss this with your insurance provider for more information.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Signature Date

_____

Printed Name