



REQUEST FOR INSURANCE INFORMATION

The information you provide on this page is used solely for the purpose of verifying your insurance benefits. Please fill out and return to one of our representatives before leaving seminar. Please complete each line. Your benefits will be verified and discussed at your first appointment. Our Facsimile is (480) 446-9475.

Today's Date: _____

Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone and Extension: _____

Doctor: _____ Phone: _____

Date of Birth: Month____ Day____ Year____

Gender: Female Male

SSN (May be required for Insurance Benefits): _____

Height and Weight (May be required for Insurance Benefits): __ Feet __ Inches __LBS

E-Mail: _____

Does your insurance require a referral prior to your visit? Yes No Unknown

Insurance Company Name: _____

Insured's Employer Name: _____

Subscriber ID: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

Insurance Company Phone Number: _____

Additional information regarding your insurance _____

Where did you hear about WLIAZ?

The Internet search word or phrase I found WLIAZ with was: _____.

TV Google LAP-BAND.com Yahoo! Ask.com AOL Obesityhelp

AZ Republic Phoenix Magazine Airport Sign Dogpile.com Lapbandchat

A friend referred me. His or her name is: _____.

A doctor referred me. His or her name is: _____.

None of the above. I was referred to WLIAZ by: _____.