ROCHESTER LIFESTYLE MEDICINE INSURANCE FORM

PATIENT INFORMATION

Patient Name:	Date of Birth:
Social Security #:	Gender: Male Female
Street Address:	City, State, Zip:
Mobile Phone: May we text you at this number? Yes No	Alternate Phone:
Email:	Preferred Method of Contact: Text Phone Email
Employer:	Employer Phone:
Emergency Contact Name:	Emergency Contact Phone:

PRIMARY CARE PHYSICIAN

Physician Name:	Phone:
Practice Name:	Fax:
Street Address:	City, State, Zip:

PRIMARY INSURANCE

Insurance Name:	Plan Type: HMO PPO POS
Street Address:	City, State, Zip:
Policy Holder Name:	Policy Holder Date of Birth:
Policy Holder Social Security #:	Policy Holder Gender: Male Female
Relationship to Patient:	Policy Effective Date:
Policy #: Employer/Group #:	Plan Phone:

SECONDARY INSURANCE

Insurance Name:	Plan Type: HMO PPO POS
Street Address:	City, State, Zip:
Policy Holder Name:	Policy Holder Date of Birth:
Policy Holder Social Security #:	Policy Holder Gender: Male Female
Relationship to Patient:	Policy Effective Date:
Policy #: Employer/Group #:	Plan Phone:

PLEASE INDICATE ANY OF YOUR KNOWN DIAGNOSES BELOW:

	Pre-diabetes		Tobacco use
	Diabetes		Alcohol use (>1 drink per day for women, >2 drinks per day for men)
	High blood pressure		Unhealthy diet
	High cholesterol		Physical inactivity
	Overweight		Heart disease
	Obesity		Family history of heart disease

PLEASE INDICATE YOUR HEIGHT AND WEIGHT BELOW. LEAVE BMI BLANK; WE WILL CALCULATE IT FOR YOU.

Height	
Weight	
BMI	

ARE YOU ABLE TO WALK UP A FLIGHT OF STAIRS UNATTENDED?

	Yes		No