Patient Demographics

I am interested in:

- ❑ Laparoscopic Gastric Bypass (Roux-en-Y)
- ❑ Laparoscopic Sleeve Gastrectomy
- ❑ Laparoscopic Gastric Band
- ❑ Medical Weight Management Program
- ❑ Undecided

Personal Information:

Last Name: ___________________________________ First: ______________________ MI: ____

Address: ____ Date of Birth: ______________

City: ___________________________________ State: ________________ Zip Code: __________

Phone number where you can be reached or receive a message during the day (circle the primary number you would like us to use)?

Home: ____________________ Cell: ____________________ Work: ______________________

E-Mail Address: ____

Do you wish to be added to the bariatric surgery support group email list?

- ❑ Yes
- ❑ No

Spouse or person to contact in case of emergency:

Last Name: ____ First: ____________________

Home: ____________________ Cell: ____________________ Work: ______________________

Your Primary Care Physician:

Physician Name: ____

Address: ____

City: ___________________________________ State: ________________ Zip Code: __________

Phone: ____

Referring Physician: (if different from Primary Care Physician)

Physician Name: ____

Address: ____

City: ________________________________ State: _______________ Zip Code: __________

Phone: ____

Primary Insurance Company:

Insurance Company: ____

Policy Holders Name: ____

Relationship to patient: ____

Policy Number: ________________________ Group/Plan Number: _____________________

Customer Service Phone Number: ____

Contact Person: ____

Provider Inquiry/Precertification phone number: ____________________________________

Secondary Insurance Company: (if applicable)

Insurance Company: ____

Policy Holders Name: ____

Relationship to patient: ____

Policy Number: ________________________ Group/Plan Number: _____________________

Customer Service Phone Number: ____

Contact Person: ____

Provider Inquiry/Precertification phone number: ____________________________________