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# BARIATRIC PATIENT INFORMATION SHEET

**TODAY'S DATE:** _____ **CLASS TIME:** _____

**NAME:** _____

**DATE OF BIRTH:** _____

**ADDRESS:** _____

_____

**HOME PHONE#:**_____ **CELL PHONE#:** _____

# BARIATRIC PATIENT CLINICAL INFORMATION

**HEIGHT:** _____ **WEIGHT:** _____ **BMI:** _____

**PLEASE REVIEW EACH MEDICAL PROBLEM BELOW.**
**CIRCLE YES IF YOU HAVE THIS MEDICAL PROBLEM.**
**CIRCLE NO IF YOU DO NOT HAVE THIS MEDICAL PROBLEM.**

**Diabetes:** Yes No **High Blood Pressure:** Yes No **Sleep Apnea:** Yes No **Acid Reflux:** Yes No **High Cholesterol:** Yes No

# PATIENT INSURANCE INFORMATION

**PRIMARY INSURANCE NAME:** _____

**PRIMARY INSURANCE ID #:** _____

**PRIMARY INSURANCE PHONE # (ON BACK OF CARD):**_____

**SECONDARY INSURANCE NAME:** _____

**SECONDARY INSURANCE ID #:** _____

**SECONDARY INSURANCE PHONE # (ON BACK OF CARD):** _____

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**FOR OFFICE USE ONLY**

**New Consult Appointment:** _____ **Provider:** _____

*Revised 2/28/19*