Weight Management Center

Bariatric Surgery Patient Information Sheet

Name: ____ **Date of Birth/Age:** __________________

Address: ____

Phone Number: ________________________ **Height:** ______ **Weight:** ________

Surgeon/Location preference: Dr. Fernandez (Greensboro) ____ Dr. McNatt (Winston Salem) _____
Dr. Powell (Winston Salem or Greensboro) ____ No preference______

Have you had weight loss attempts/diets in the past? Yes or No
If yes, please list here:____

2 year weight history: 2019 ___________ 2018 ____________

Medical History: *(please mark those that apply and include year diagnosed)*

- ☐ Diabetes
- ☐ High Blood Pressure (if yes, list medications)
- ☐ Heart Disease
- ☐ High Cholesterol (if yes, list medications)
- ☐ Obstructive Sleep Apnea requiring CPAP or BiPAP
- ☐ Joint Disease related to obesity (medical record documentation required)
- ☐ Pseudotumor Cerebri

Have you had a previous weight loss surgery? Yes or No
If yes, please list type and year of procedure: ____

Have you been hospitalized for depression, anxiety, or other related problems? Yes or No
If yes, please give the date(s) and reason(s): ____

Created 8.7.18
Updated 1.7.20

PATIENT INFORMATION

Name (Last, First, Middle):____

Maiden Name: ________________________ Mother's First Name: ____

DOB: _______________________ Email Address: ____

Address:____

Telephone#__________________________Cell#_________________________Work#____________________________________

Sex: Male____ Female_____ Race: ____________________________ Marital Status: ________________________________

GUARANTOR INFORMATION

Relationship to Patient: ______________________

Insurance Card Holder's Name: _____________________________________ DOB: ______________________________________

Address: ____ City, St, Zip: __________________________________

Telephone#________________________________ Effective Date of Insurance: __________________________________

NEAREST RELATIVE INFORMATION

Emergency Contact Name: ______________________________Emergency Phone#______________________________________

Nearest Relative's Name: _______________________________Relationship to Patient: _____________________________________

Address Line: ____

City, State: ______________________________Zip:____________________ Telephone#:_________________________________

EMPLOYMENT HISTORY

Employer: ____

Address: ___________________________________ City, State: _________________________ Zip Code: _________________

Effective Date of Employment: ___________________________

PATIENT'S ASSIGNED PROVIDER

Family Medical Doctor: ____

INSURANCE INFORMATION

Name of Ins. Company: ____ Ins Comp tele# _________________________________

Insurance Comp. Address: ____

ID Number: ____ Group Number: ____

Patient's Relationship to Card Holder: ____________________________Card Holder's Name: _________________________________

Card Holder's DOB: ________________________________

Card Holder's Sex: ___________________________Card Holder's Employer: ____