Name: ____
Last First MI

Surgical Weight Loss Center

Date Attended Seminar: ______________________________

DOB	Last 4 Digits of SSN	Age	Race

Street Address	City	State	Zip Code

Cell Phone #	Home/Work Phone #	Email Address

Primary Care Physician or Practice Name	Who May We Thank For Referring You/How did you hear about us?

Marital Status

Single **Married** ☐**Divorced** ☐ **Widowed**

Main Support Person Through This Process:

____

Relationship To You: ______________________________

Education Level: Highest Degree Earned

- ☐ **HS Diploma**
- ☐ **Associate Degree**
- ☐ **Baccalaureate Degree**
- ☐ **Master Degree**
- ☐ **Post Graduate Degree**

____
Degree Earned

Employment:

Full Time **Part Time** **Student** **Not Employed** **Retired** **Disabled**

Employer	Position	How Long

Height: ______________ **Weight:** ______________ **BMI:** ____________ **Gender: (**M)_____ (F)_____

Insurance

Primary Insurance Provider	ID #	Policy Holder

Policy Holder Employer	Relationship to Policy Holder

Secondary Insurance Provider	ID #	Policy Holder

Policy Holder Employer	Relationship to Policy Holder

Have You Contacted Your Insurance Company Regarding Bariatric Benefits? YES____ NO____

Bon Secours

☐

* Have you previously had a bariatric (weight loss) surgical procedure? ____ YES ____ NO

If "**YES**", What procedure ______________________________ Year __________

* Have you participated in any other <u>Surgical</u> Weight Loss program? _____ YES ____ NO

If "**YES**", Which program ______________________________

* Have you attempted non-surgical approaches for long-term weight loss? _____ YES ____ NO

If "**YES**", list the most recent ______________________________

Which procedure are you interested in? ______________________________

Please note desired surgeon, if you have a preference:

Dr. David Anderson **Dr. Jessica Gonzalez Hernandez**

Check the box to indicate ALL that apply for PAST & PRESENT DIAGNOSIS OF:

- ☐ Barrett's Esophagus
- ☐ Difficulty Swallowing
- ☐ Nissen Fundoplication
- ☐ GERD / Reflux
- ☐ Diabetes Type 2 (adult onset)
- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ MI (Heart attack)
- ☐ CVA (Stroke)
- ☐ TIA (Ministroke)
- ☐ CABG (Coronary Artery Bypass Graft)
- ☐ Heart Catherization or Stint
- ☐ Pacemaker
- ☐ PVD (Peripheral Vascular Disease)
- ☐ DVT (Blood Clot in Leg)
- ☐ Pulmonary Embolism (Blood Clot in Lung)
- ☐ Blood Clotting Disorder
- ☐ High Cholesterol/Triglycerides
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Asthma
- ☐ Diagnosis of Obstructive Sleep Apnea
- ☐ Liver Disease
- ☐ Hepatitis A, B, or C (circle all that apply)
- ☐ Renal Failure (Kidney Failure)
- ☐ Renal Disease (Kidney Disease)
- ☐ Cancer
- ☐ Osteoarthritis
- ☐ Impaired Hearing
- ☐ Dental Issues
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ PTSD
- ☐ ADHD (Attention Deficit)
- ☐ Eating Disorder(s)
- ☐ Under the Care of a Mental Health Professional
- ☐ Previous Care of Mental Health Professional
- ☐ Previous In/Out Patient Mental Health Care
- ☐ Other Mood/Personality Disorder
- ☐ Present Tobacco/Nicotine Use or Vaping/E-Cigs
- ☐ Past Tobacco Use (Quit Date _____/______/______)

If you would like for us to know any additional information about you, please list it below

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