PATIENT DEMOGRAPHIC INFORMATION

Date:____________________

Name:____

Age:________ Date of Birth:____________________ Social Security #____________________ ☐ Male ☐ Female

Ethnicity: ☐ African American ☐ Arabic ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

CHECK BOX NEXT TO PHONE NUMBERS WHERE MESSAGES CAN BE LEFT.

☐ Home Phone: ( )_____–__________ ☐ Cell Phone: ( )_____–__________ ☐ Work Phone: ( )_____–__________

Address:______________________________ City/State/Zip:______________________________

E-mail Address:____

Height:________Weight:_________BMI:__________ PLEASE BE AS ACCURATE AS POSSIBLE TO PREVENT ANY DELAYS IN MEETING YOUR NEEDS.

I am interested in having ☐ Gastric Bypass Surgery ☐ Sleeve Gastrectomy ☐ Genereal ☐ Have you had a previous bariatric procedure?

Have you previously attended an Information Session with New Life Weight Loss Center? ☐ Yes ☐ No If yes, when?______________

How did you hear about us? (Please check all that apply) ☐ Friend Referral ☐ Television Ad ☐ Print Ad ☐ Online Search ☐ Radio Ad

☐ Facebook Ad ☐ Physician Referral______________________________ ☐ Other______________________________

Primary Care Physician and/or Referring Physician:____

Occupation:______________________________ Employer:______________________________

If you plan on receiving assistance from your insurance company, please provide the following information:

Insurance Provider:______________________________Insurance Phone#______________________________

Policy #____________________Name of Insured:____________________Date of Birth of Insured: ______________

I attended an Information Session presented by New Life Weight Loss Center and had an opportunity to ask or e-mail questions regarding presentation.

Signature **X** ____

Locate and complete the AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION form located in your packet.

LOSE WEIGHT, GAIN SO MUCH **MORE**.

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