

BARRINGTON BARIATRIC CENTER

~ The Path to a Healthier Lifestyle ~

Information Sheet

Today's Date: _____

Name and Address: _____

Social Security #: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ **May we call you at home: Y N

**May we leave a message at home: Y N

Email Address: _____ **May we contact you via email: Y N

Sex: M F

How were you referred to our program? _____

Employer Name, Address, Phone Number: _____

Referring Physician Name, Address, Phone Number: _____

Emergency Contact Name: _____

Relationship: _____

Phone #: _____

Spouse's Name: _____

Phone #: _____

Have you completed your Health History forms? Y N

Current BMI (if known):

Current Weight (if known)

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Do you give consent to release patient identifiable information for the purpose of conducting insurance inquiry related to your benefits for bariatric surgery? Y N

Primary Insurance Information

Name of Insurance Company: _____
Insurance Address: _____
Insurance Phone #: _____
Insurance Policy #: _____
Group ID#: _____
Policyholder's Name: _____
Policyholder's relationship to patient: _____
Policyholder's date of birth: _____
Policyholder's Employer Name: _____
Policyholder's Social Security #: _____

Secondary Insurance Information

Name of Insurance Company: _____
Insurance Address: _____
Insurance Phone #: _____
Insurance Policy #: _____
Group ID#: _____
Policyholder's Name: _____
Policyholder's relationship to patient: _____
Policyholder's date of birth: _____
Policyholder's Employer Name: _____
Policyholder's Social Security #: _____

I _____ give permission for Barrington Bariatric Center to use the information on this form for the purpose of conducting insurance research, collecting medical documentation and communicating with referring physicians.

Signature: _____ Date: _____