Bariatric Patient Information Sheet

Today's date:

Patient's Name:	DOB:	Last 4 digits of SS#
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	
E-mail:	Cell Phone:	
How did you hear about us? __ your physician __ insurance co.	__another patient (who_____) __online _advertisement (where_____) _other	

Weight:	Height:	BMI:

Name of insurance company: ____Aetna ___ BCBS ____UHC ____Cigna ___ Other: _____	Type of policy? ____HMO ____PPO _____POS ____EPO ____HRA Case Mngr:_____
Address for Claims:	Phone Number for Member/Customer Service:
Policy/Member Identification card:	Group Number:

Are you a smoker?

☐ Yes ☐ No

Which Surgery are you considering?

Gastric Banding_____ Roux En Y Gastric Bypass _____ Undecided_____ Gastric Sleeve_____

If outpatient surgery is recommended, I understand that the physicians on staff at Atlanta General and Bariatric Surgery Center providing medical services are in fact owners of the facility. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Atlanta General and Bariatric Surgery Center.

Patient's Signature:_____ **Date:**_____