PLEASE PRINT CLEARLY Date_____

Name_____Date of Birth_____

Social Security_____/_____/_____ Best Phone Contact_____

Address_____

City_____ State/Country_____ Zip_____

Email Address_____

Height_____ Weight_____ BMI_____

Referring Physician Name_____

Referring Clinic Phone_____ Address_____

Employer Name/Company_____

Medical Conditions ☐Sleep Apnea ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Pacemaker

Other concerns based on your weight_____

Primary Insurance

Insurance Provider_____

Phone_____

ID#_____

Group#_____

Primary Insured Name_____

Relationship to You_____

Their Date of Birth_____

Employer_____

Secondary Insurance

Insurance Provider_____

Phone_____

ID#_____

Group#_____

Primary Insured Name_____

Relationship to You_____

Their Date of Birth_____

Employer_____

What Procedure are you interested in? ☐LapBand ☐Sleeve Gastrectomy ☐Gastric Bypass ☐Revision

By signing below, you give Southern Nevada Bariatrics permission to verify your Bariatric Insurance benefits through your provider. Someone from the office will contact you to go over your benefits and set up your initial appointment.

_____ _____

Your Signature Date