

Info Session Date: \_\_\_\_\_

RWC MR #: \_\_\_\_\_



# BARIATRIC PATIENT REGISTRATION FORM

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone (if we can contact you at work): \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ GRP#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer Group (if applicable): \_\_\_\_\_

Does your primary insurance require a referral to see a surgeon?  Y  N If yes, have you asked your PCP to request one?  Y  N

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ GRP#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer Group (if applicable): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Have you ever seen a Rockwood Bariatric Surgeon:  Y  N Surgeon preference:  Bright  Rawlins  Spitz  No Preference

Primary Care Provider: \_\_\_\_\_ (RWC) Referring Provider: \_\_\_\_\_ (RWC)

Current Weight Loss Method: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Have you been diagnosed with any of the following:  Diabetes  Sleep Apnea  Hypertension

Which surgery interests you most?  Band  Sleeve  Bypass

### INTERNAL USE ONLY

CM Notes: \_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Ref: \_\_\_\_\_

PRIMARY	Benefit	Amount Met		
Lifetime Max			Band Sleeve RNY No Benefit	Dietary:
Ind Ann OP				
Fam Ann OP				
Ind Ded				
Fam Ded				
Coins				
Hosp Copay				
				Need Consult Auth
				Need Surgery Auth

SECONDARY: \_\_\_\_\_

CRITERIA: BMI: \_\_\_\_\_ Comorbidities: \_\_\_\_\_

INSURANCE REQUIREMENTS: \_\_\_\_\_

Psych: \_\_\_\_\_ Dietary: \_\_\_\_\_ Weight Loss: \_\_\_\_\_ MSWLP: \_\_\_\_\_

Other: \_\_\_\_\_

CON 1 Appointment Date: \_\_\_\_\_ time: \_\_\_\_\_ Provider: \_\_\_\_\_

Dietary Appointment Date: \_\_\_\_\_ time: \_\_\_\_\_ Provider: \_\_\_\_\_