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	Dietary:
Ind Ann OP			Sleeve	
Fam Ann OP				
Ind Ded			RNY	
Fam Ded			No Benefit	
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: ____