



# The Methodist Hospital

## Weight Management Center

Date: \_\_\_\_\_

<b>PATIENT DATA</b>	LAST NAME	FIRST NAME	MI	BIRTH DATE	SSN
	PATIENT ADDRESS:			CITY, STATE, ZIP	
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME TELEPHONE:		WORK/ALTERNATE TELEPHONE & EXT.	
	HEALTH PROBLEMS: CHOOSE ALL THAT APPLY			EMERGENCY CONTACT PERSON:	
	<input type="checkbox"/> DIABETES <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> SLEEP APNEA <input type="checkbox"/> REFLUX DISEASE <input type="checkbox"/> OTHER: LIST _____			NAME: _____ PHONE: _____ RELATIONSHIP: _____	
HEIGHT: _____ WEIGHT: _____ BMI: _____	PHYSICIAN:		SURGERY:		
		<input type="checkbox"/> GARTH DAVIS, MD <input type="checkbox"/> ROBERTS DAVIS, MD <input type="checkbox"/> ROBERT MARVIN, MD <input type="checkbox"/> PATRICK REARDON, MD		<input type="checkbox"/> LAPBAND® <input type="checkbox"/> ROUX-EN-Y GASTRIC BY-PASS	
<b>INSURANCE INFORMATION</b>	RELATIONSHIP OF PATIENT TO THE INSURED: _____ SELF _____ SPOUSE				
	INSURANCE COMPANY NAME: _____				
	INSURANCE ADDRESS: _____				
	NAME OF INSURED: _____				
	INSURED'S SOCIAL SECURITY: _____ INSURED'S DATE OF BIRTH: _____				
	GROUP # _____ ID# _____				
	EMPLOYER: _____				
INSURANCE CO TELEPHONE #: _____					
<b>FOR OFFICE USE</b>					
DIAGNOSIS/CLINICAL PROBLEM: ICD9 Code			Morbid Obesity	278.01	
<b>CPT CODES:</b>					
			LapBand	43770	
			Roux-en-Y Gastric By-Pass	43846	
			Psych Eval	90801	