SOUTHWEST BARIATRIC SURGEONS, PLLC

Tim L. Faulkenberry, M.D., FACS Mark R. Sherrod, M.D., FACS Nancy G. Marquez, M.D., FACS
Steven M. Fass, M.D., FACS Eric M. Acheson, M.D., FACS Erik G. Lough, M.D., FACS Romeo A. Lainez, M.D.

PLEASE COMPLETE AND FAX THIS FORM TO (512) 334-1890, ATTN: PATIENT ADVOCATE
PLEASE INCLUDE A COPY (FRONT & BACK) OF YOUR INSURANCE CARD (incl. secondary insurance if have)
AND THE SIGNED "NOTICE OF PRIVACY PRACTICES RECEIPT"

We will contact your insurance company, then call you regarding an appointment. Please allow 10 business days.

How did you hear about Southwest Bariatric Surgeons? _____

Do you have a preference for one of our Southwest Bariatric Surgeons physicians? *Please circle below.*

Dr. Faulkenberry *Dr. Sherrod* *Dr. Marquez* *Dr. Fass*

Dr. Acheson *Dr. Lough* *Dr. Lainez* *No Preference*

Please indicate choice of surgical procedure: ☐ Adj. Gastric Band ☐ Gastric Bypass ☐ Sleeve Gastrectomy

Which seminar did you attend? Location: _____ Date: _____

PRELIMINARY MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____

Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____

Home Address: _____ _____

STREET ADDRESS CITY / STATE / ZIP CODE

Email Address (will not be shared): _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Height: _____ FEET _____ INCHES Weight: _____ LBS Calculated BMI:
(Please leave BMI blank. Office will complete.)

PRIMARY INSURANCE INFORMATION: _____ No health insurance (self-pay)

Insurance Carrier: _____ Benefits Phone # : _____

Subscriber Policy ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

SECONDARY INSURANCE INFO: Insurance Carrier: _____ Benefits Phone #: _____

Subscriber Policy ID #: _____ Subscriber Name: _____ Subscriber DOB: _____

Do you already know that you will be self-pay because of a policy exclusion? ____ Yes *(We still need your insurance info.)*

MEDICAL HISTORY:	**YES**	**NO**	**DETAILS**
TYPE 2 DIABETES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
HEART DISEASE	☐	☐	
SLEEP APNEA	☐	☐	
ASTHMA/BREATHING PROBLEMS	☐	☐	
ARTHRITIS OR JOINT PAIN	☐	☐	
NEUROLOGICAL PROBLEMS	☐	☐	
GALLSTONES	☐	☐	
REFLUX OR HEARTBURN	☐	☐	
HIGH CHOLESTEROL	☐	☐	
GASTRIC OR DUODENAL ULCER	☐	☐	
HEPATITIS OR LIVER DISEASE	☐	☐	
BACK PAIN / SURGERY SECONDARY TO OBESITY	☐	☐	
CROHN'S DISEASE	☐	☐	
LIVER CIRRHOSIS	☐	☐	
AUTOIMMUNE DISORDER / LUPUS	☐	☐	
PREVIOUS BARIATRIC SURGERY	☐	☐	

OTHER: Please explain: _____

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Patient Name: _____ Date of Birth (MM/DD/YY): _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

OTHER PHYSICIANS YOU WOULD LIKE US TO SHARE YOUR TREATMENT WITH:

PRIMARY CARE: _____ PHONE: _____

CARDIOLOGIST: _____ PHONE: _____

PULMONOLOGIST: _____ PHONE: _____

ONCOLOGIST: _____ PHONE: _____

INTERNAL MEDICINE: _____ PHONE: _____

GASTROENTEROLOGIST: _____ PHONE: _____

GYNECOLOGIST: _____ PHONE: _____

WEIGHT LOSS HISTORY:

	START DATE	END DATE	AMOUNT OF WEIGHT LOSS ACHIEVED
ATKINS DIET® / LOW CARB			
WEIGHT WATCHERS®			
CALORIE COUNTING			
DEXATRIM®			
HYPNOSIS			
JENNY CRAIG®			
LOW FAT DIETS			
NUTRISYSTEM®			
OVEREATERS ANONYMOUS®			
PHEN FEN®			
PRESCRIBED DIET PILLS			
SLIM FAST®			
SUPERVISED DIET WITH MD OR RD			
OTHER:			