Patient Information

Last Name	First Name	Middle Name	Suffix	Date

Social Security #	Date of Birth	Home Phone	Cell Phone

Mailing Address	Apt/Lot	City/State	Zip Code	Primary Care Physician

Email Address	Referred By

Height	Weight	BMI	Preferred Language

Medical History

Medications

Insurance Information

Employer	Insurance Name

Insurance Policy ID	Group #	Insurance Phone #

General Information

Interested In (Please check the following that apply)

Gastric Bypass ( ) Lap Band ( ) Sleeve ( ) Plication ( ) Undecided ( )

Referred To (Please check the following)	Appointment Info	Have You Attended a Weight Loss Surgery Seminar (if yes)
Dr. Reyes ( ) Dr. Garza ( )	Date:___________ Time:___________	Location: ________________ Date: _______

How Did You Hear About Us