

Surgical Institute of South Dakota

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Patient Information Form for Gastric Bypass/Banding

(Please fill out all of the information by printing your answers)

Personal Information

Name: _____ Age: _____

DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Full-time: _____ Part-time: _____

Employer: _____

Address: _____

Physician Information

Family Physician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Address: _____

Office Use Only: Weight: _____ Height: _____ BMI: _____

Vital Signs: T _____ P _____ R _____ B/P _____

Dietary Consult Scheduled Date: _____

Behavioral Health Consult Scheduled Date: _____

Body Size and Diet History

Weight Now: _____ **Height:** _____

At what age did you become overweight: _____

Diet History (Please fill out this section completely, as it will be used by dietician also.)

Diet Name/Medications	Year	Length of Time	MD Supervised	Pounds Lost	Weight Regained

Have you tried exercise to lose weight? Yes No

Do you do daily exercise now? Yes No

What type of exercise do you do? _____

Additional Information: _____

Medical History (Please fill out appropriately and describe any and all treatment)

Illness/Condition	Yes	No	Year Diagnosed/Treated
Diabetes			
Heart Disease			
Acid Reflux			
Arthritis/Degenerative Joint Disease			
Cancer Type:			
High Blood Pressure			
Emphysema/Asthma			
Sleep Apnea			
Stroke			
Blood Clots			
Peripheral Vascular Disease			
Neurological Disease Type:			
Depression			
Gallbladder Disease			
Kidney Disease			
Thyroid Disease			
Irritable Bowel/Colitis/Crohn's			
Liver Disease			
Pancreas Disease			
Hernia Type:			
Other:			
Other:			

Family History

Please fill out accurately

Disease/Condition	Mother	Father	Siblings	Grandparents
Obesity				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Cancer				
Alcohol Abuse				
Substance Abuse				
Depression				
Other:				
Other:				

Social History

If you are a tobacco user, please let us know what kind

Product	# Years	Year Started	Year Stopped	# Per Day
Cigarettes				
Cigars/Pipe				
Chewing Tobacco				

Do you ever drink alcohol? Yes No

What is your drink of choice? _____

How often do you drink? _____

Do you use street drugs? Yes No

If so, what kind? _____ How often? _____

Insurance Information

Name: _____ DOB: _____

Subscriber Name on Card: _____

Insurance Company: _____

ID #: _____ Group #: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Coverage Specifics

Is Gastric Bypass a plan exclusion with your insurance? Yes No

Is there a specific hospital that your insurance requires you to use? Yes No

Which hospital? _____

What is the effective date of your insurance? _____

What is your deductible you have to meet? _____

What is the percentage insurance will pay after you have met your deductible? _____

What requirements does your insurance have regarding gastric bypass? _____

Does your insurance require a referral from your Primary Care Doctor? Yes No

Contact Name at insurance company: _____

Fax number to send any prior approval information: _____