Valley Health Metabolic & Bariatric Program Demographic Sheet

Valley Health Metabolic and Bariatric Program Demographic Sheet

Last ______________________ First ______________________ Middle __________

SSN ______________________ Gender Male Female Date of Birth __________

Address ____

City ______________________ State ______________________ Zip __________

Home # ______________________ Cell # ______________________ Work # __________

Email address (please write clearly) ______________________________

Need Interpreter Yes No Preferred language ______________________

Marital Status Divorced Married Separated Single Widowed

Ethnicity Hispanic/Latino Non Hispanic /Latino
Patient Declined Unavailable

Race American Indian or Alaskan Native Asian
Black or African American More than one race
Native Hawaiian or other Native Pacific Islander Other
Unavailable White or Caucasian

Primary Care Provider Name ______________________ Phone __________

Referring Provider Name ______________________ Phone __________

Emergency Contact Name ______________________ Phone __________

Relationship ______________________

Employer Name ______________________ Phone __________

Employment Status Full time Part time Retired Self employed Not employed

Primary Insurance __________ Subscriber Name __________ DOB __________

Secondary Insurance __________ Subscriber Name __________ DOB __________

Height (inches) ______ Weight (pounds) ______ Payment Method 9 Self Pay 9 Insura

Rev. 190619

Valley Health Metabolic & Bariatric Program Demographic Sheet

I am interested in Surgery

Duodenal Switch	Gastric Bypass
Sleeve Gastrectomy	Revision Surgery

- ☐ I am interested in the Medical program

Have you had bariatric surgery before? Yes No If so, when? ________________________

How did you hear about us?

Employer	Newspaper	
Provider Referral	Valley Health Website	
	Radio	Wellness Fair
Insurance		Internet
TV	Magazine	Other ____________
Word of Mouth		

Valley Health Metabolic & Bariatric Program Demographic Sheet

I am interested in services provided by Valley Health Metabolic & Bariatric Program. I give my permission to release any information to determine my eligibility, benefits, co-payments or any out-of-pocket expenses to Valley Health Metabolic and Bariatric Program.

Primary Insurance Information: Please provide copies (front and back) of your insurance cards.

Insurance Name (please include State: for example Blue Cross Blue Shield of Virginia): ______________________________
Does your insurance card have PPO, HMO or EMO? ______________________________
Insurance Address (typically located on back of card): ______________________________
Address claims are filed to (typically located on back of card): ______________________________
Identification Number or Member ID (located on front of card): ______________________________
Group Number (located on front of card): ______________________________
Provider Telephone Number (typically located on back of card): ______________________________
Customer Service Telephone Number (typically located on back of card): ______________________________
Employer of Subscriber (Employer of person responsible for obtaining insurance): ______________________________

Secondary Insurance Information: Please provide copies (front and back) of your insurance cards.

Insurance Name (please include State: for example Blue Cross Blue Shield of Virginia): ______________________________
Does your insurance card have PPO, HMO or EMO? ______________________________
Insurance Address (typically located on back of card): ______________________________
Address claims are filed to (typically located on back of card): ______________________________
Identification Number or Member ID (located on front of card): ______________________________
Group Number (located on front of card): ______________________________
Provider Telephone Number (typically located on back of card): ______________________________
Customer Service Telephone Number (typically located on back of card) ______________________________
Employer of Subscriber (Employer of person responsible for obtaining insurance): ______________________________

I also give permission for any insurance company to inform Valley Health Metabolic and Bariatric Program of the reasonable and customary reimbursements for my surgical procedure. The information needed from your insurance card will assist the office in ensuring coverage and criteria received is accurate. If you are able to provide us with a copy of your insurance card (front and back) please email, fax or mail the copy as soon as possible.

Metabolic & Bariatric services are considered elective and not eligible for charity/ financial assistance

I have watched the Valley Health Metabolic and Bariatric Program online information session video in its entirety.

☑ Signature:______________________________ Date: ______________________________

Please contact the office if you have not received a response within one business day after submission of form.