Are you interested in…
- ☐ **Gastric Bypass**
- ☐ **Lap Band**
- ☐ **Sleeve gastrectomy**
- ☐ **I am not sure**

CRAIG G. CHANG MD, FACS
2700 CITIZENS PLAZA, SUITE 401
VICTORIA, TEXAS 77901
Toll Free: 877-232-8500 OR 361-574-1840
Fax: 361-574-1850

BARIATRIC HEALTH QUESTIONNAIRE

Please complete the document and return to the above address. Dr. Chang will review your information to determine eligibility for surgery. We will contact you to schedule your initial consultation.

Date________________________

PATIENT NAME____
FIRST MI LAST

MAILING ADDRESS______________________________CITY__________________STATE___________ZIP_____________

HOME PHONE____________________WORK PHONE___________________CELL PHONE___________________

EMAIL ADDRESS____SOCIAL SECURITY #____________________

BIRTHDATE_____________________AGE_______SEX_________MARITAL STATUS_______________________

PATIENT'S EMPLOYER____PHONE_______________________

EMPLOYER'S ADDRESS______________________________CITY__________________STATE_____________ZIP____________

SPOUSE'S NAME___________________________________EMERGENCY CONTACT NAME___________________________

EMERGENCY CONTACT PHONE________________________RELATIONSHIP_____________________________

RESPONSIBLE PARTY____PHONE________________________________

INSURANCE INFORMATION

PRIMARY
Insurance Company_____________________________
Address_______________________________________
City,St,Zip____________________________________
Phone #_______________________________________
Policy Holder__________________________________
Birthday______________________________________
Social Security #_______________________________
Group Number_________________________________
Policy Number_________________________________
Employer______________________________________

SECONDARY
Insurance Company_____________________________
Address_______________________________________
City,St,Zip____________________________________
Phone #_______________________________________
Policy Holder__________________________________
Birthday______________________________________
Social Security #_______________________________
Group Number_________________________________
Policy Number_________________________________
Employer______________________________________

BARIATRIC HEALTH QUESTIONNAIRE

PATIENT NAME____

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I the undersigned, by presenting for services, request and authorize evaluation, diagnosis and treatment by my physician and/or his/her designee. I further hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits without obtaining my signature on each and every claim.

AS A COURTESY TO YOU, we will file your insurance claim. It is your responsibility to see that your insurance pays on time. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You may be asked to pay a portion of the charges prior to scheduling surgery. Failure to pay your bill could result in your account being turned over to a collection agency.

I hereby authorize my insurance benefits to be paid directly to Craig G. Chang, MD, PA and acknowledge that I am financially responsible for all charges as a result of services rendered to me.

Signature____**Date**________________________________

Print Name____

- -

MEDICAL HISTORY

Height_________feet__________inches

Weight___________lbs.

Weight 5 years ago____________lbs.   How many years have you been overweight_______

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

YES **NO**

DIABETES MELLITUS   HOW LONG?________________

HYPERTENSION (HIGH BLOOD PRESSURE)

JOINT PAIN (ARTHRITIS) IN FEET, KNEES OR HIPS

LOW BACK PAIN

SLEEP APNEA (STOP BREATHING DURING SLEEP)

GASTROESOPHAGEAL REFLUX (HEARTBURN)

URINARY STRESS INCONTINENCE

ASTHMA

GALLBLADDER ATTACKS (CHECK NO IF REMOVED)

CONGESTIVE HEART FAILURE

HEART ATTACK OR CORONARY DISEASE OR ANGINA

DEEP VEIN CLOTS (CLOTS IN LEGS OR LUNGS)

DEPRESSION

HEAVY PERIODS OR IRREGULAR PERIODS

INFERTILITY (FEMALES OF CHILD BEARING AGE)

HIGH CHOLESTEROL OR HIGH TRIGLYCERIDES

LOWER EXTREMITY SWELLING

SHORTNESS OF BREATH UPON EXERTION

Open this PDF, fill it out, and save it on your computer. When you are done, you can email it to our offices at questionnaire@drcraigchang.com You can also print it out and fax it you our office at (361)574-1850.