Saint Luke's Hospital
Kansas City, MO 64111

Saint Luke's Center for Surgical Weight Loss
Patient Demographics

PLEASE PRINT ALL INFORMATION IN BLUE OR BLACK INK
IT IS VERY IMPORTANT THAT ALL INFORMATION IS COMPLETE SO WE CAN FILE INSURANCE PROPERLY

Last name: ____________________ First name ____________________ M.I. ________

Previous legal name: ____

Sex: ☐ Male ☐ Female Date of birth: ______________ Social security number __________

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Street address: ____

City: ____________________ State: ______________ Zip: __________

Home phone: ____________________ Cell phone: ____________________

Email: ____

Employer: ______________________________ ☐ Full time ☐ Part time

Patient occupation: ____

Work address: ____

Work phone number: ______________________________ Extension: __________

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other __________

Primary physician name and address: ______________________________

____

Referring physician name and address: ______________________________

____

Spouse (or other responsible party): ______________________________

Address: ______________________________ Phone: ______________

In case of emergency, notify: ______________________________

Relationship: ______________________________ Phone: ______________

Procedure that I am interested in: ☐ Laparoscopic gastric bypass ☐ Lap®Band ☐ Realize®Band

☐ Gastric Sleeve ☐ Revision of previous procedure (describe): ______________________________

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Form Number (Rev. 7/29/2008)

Patient Label