

PACIFIC LAPAROSCOPY

SURGERY FOR MORBID OBESITY
ADVANCED LAPAROSCOPIC AND ENDOCRINE SURGERY

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Patient Preliminary Insurance Information

Patient Name:

Address:

City:

State:

Zip:

Date of Birth:

Height:

Current Weight:

Home Telephone:

Business Telephone:

Mobile Telephone:

Email Address:

Please list all previous surgeries and hospitalizations:

PROCEDURE/DIAGNOSIS

DATE

HOSPITAL NAME/LOCATION

Have you had any of the following *obesity-related* conditions?

Diabetes Hypertension Sleep Apnea Hypercholesterolemia Joint pain

Please list any other serious *obesity related* conditions:

Intended means for payment:

Self Pay Insurance Pay

Preferred Surgery: Duodenal Switch Sleeve Gastrectomy
 Revision (past failed weight loss surgery) Do Not Know

Employer Providing Insurance Coverage (note this could be your spouses employer)?

**PLEASE FAX OR EMAIL A LEGIBLE COPY (FRONT AND BACK) OF YOUR
INSURANCE CARD**

415-668-2010

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