# LIFE BACK Weight Loss Center

1-844-LIFE-BAC(K) 1-844-543-3222

info@lifebackweightloss.com www.lifebackweightloss.com

Consultation Request Form

## PATIENT

Name ______ Sex ______ Social Security # ______

Height ______ Weight ______ BMI ______ Date of Birth ______

Address ______ City ______ State ______ ZIP ______

Patient Phone # ______ Patient Email ______

## INSURANCE

Provider ______ Policy Holder Name ______ Date of Birth ______

Relationship to Patient ______ Employer ______

Insurance ID # ______ Group # ______

Referral Authorization # (if required) ______

## MEDICAL HISTORY/COMORBIDITIES (please check all that apply)

- ☐ Acid Reflux (GERD)
- ☐ Degenerative Joint Disease
- ☐ Asthma
- ☐ Congestive Heart Failure/Class ______
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Stomach/Bowel Problems
- ☐ Stroke
- ☐ Transient Ischemic Attack (TIA)
- ☐ Other (please describe any other medically relevant conditions): ______

Medications ______

Previous Weight Loss Attempts ______

☐ I have attached this patient's recent laboratory results for your review.

## REFERRING PHYSICIAN

Name of Referring Physician ______

Referring Physician Phone # ______ Referring Physician Fax ______

Referring Physician Email ______

Preferred method of communication: ☐ Phone ☐ Fax ☐ Email

**When complete, please fax to 619-209-7888 or email to info@lifebackweightloss.com**