

Advanced Bariatric Centers, PLLC<sup>®</sup>  
20 Medical Village Drive, #105  
Edgewood, KY 41017  
(859) 426-4741  
(859) 426-7010 fax  
[advancedbariatriccenters@fuse.net](mailto:advancedbariatriccenters@fuse.net)



### Personal Data Sheet

Obesity and its associated diseases and risk factors increase mortality and surgical complications. Therefore, it is imperative for safety and insurance purposes that a detailed medical history be performed to justify the associated risk of surgery. Please try to answer the following questions as best as you can and email to [advancedbariatriccenters@fuse.net](mailto:advancedbariatriccenters@fuse.net) or fax it back to us at 859-426-7010. Then pick up the Personal Weight Loss History, complete it, and request an appointment by calling the office at 859-426-4741. Use this form to start collecting the information you will need to begin your file. Thank you.

YOUR NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
BUSINESS PHONE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
MOBILE PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
SSN \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
EMERGENCY \_\_\_\_\_  
CONTACT & TEL # \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** (you must have one in order to qualify for the surgery. We can help you find one if you do not have a physician.)

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_  
FAX \_\_\_\_\_

**SPECIALIST PHYSICIAN** (pulmonologist, gastroenterologist, endocrinologist, internist, cardiologist, etc.)

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_  
FAX \_\_\_\_\_

**PSYCHOLOGIST/ PSYCHIATRIST / NURSE PRACTITIONER**

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_  
FAX \_\_\_\_\_