Texas Health Hospital Rockwall

Patient Demographic Form

About You

Your Name: ______________________________ ☐ **Male** ☐ **Female**

Address: ______________________________ **City, State and Zip:** ______________________________

Phone Number: ______________________________ **Email**: ______________________________

Date of Birth: ______________________________ **Driver's License Number:** ______________________________

Social Security Number: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Significant Other/Partner

Occupation:______________________________

Employer: ______________________________ **Work Phone:** ______________________________

How did you hear about us? ______________________________

Insurance

Primary Insurance Company: ______________________________ **Phone Number:** ______________________________

Group Number: ______________________________ **ID Number:** ______________________________

Principal Insurance Holder: ☐ Self ☐ Spouse ☐ Partner ☐ Other: ______________________________

Name:______________________________

Social Security Number: ______________________________ **Date of Birth:** ______________________________

Secondary Insurance Company: ______________________________ **Phone Number:** ______________________________

Group Number: ______________________________ **ID Number:** ______________________________

Emergency Contact

Name:______________________________ **Phone Number:** ______________________________

Relationship: ☐ Spouse ☐ Partner ☐ Parent ☐ Friend ☐ Other: ______________________________

Primary Care Physician

Name: ______________________________

Address: ______________________________ **City, State and Zip:** ______________________________

Phone Number: ______________________________ **Fax**: ______________________________

Weight Loss Journey

Current Height: ____________________ **Current Weight:** ____________ **Current BMI:** ____________________

I'm interested in:

☐ Medical Weight Loss ☒ Gastric Sleeve ☐ Gastric Bypass

☐ Revision; I have previously had: ______________________________

Texas Health Hospital® ROCKWALL