



# Lafayette General Medical Center

## Demographic Sheet

Date: \_\_\_\_\_

**PLEASE PRINT**

Last Name:		First Name:		MI:	
Social Security #:		Date of Birth:		Age:	
Address:					
City:		State:		Zip:	
Home Phone:	( )	Beeper/Pager:	( )		
Work Phone:	( )	Fax:	( )		
Cell Phone:	( )	Email address:			
Marital Status:		Spouse's Name:			
Occupation:		Employer:			
Employer Address:					
Insurance Company:					
Have you attended an Informational Session before?		<input type="checkbox"/> Yes    If yes, where? _____ <input type="checkbox"/> No			
I am interested in:	<input type="checkbox"/> Gastric Bypass Surgery <input type="checkbox"/> Adjustable Gastric Band <input type="checkbox"/> Gastric Sleeve				
How did you hear about us?		<input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Other _____		<input type="checkbox"/> Patient _____ <input type="checkbox"/> Doctor _____	
Have you visited www.lafayettegeneral.com?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
The information below is taken now to have on file for future use.					
<b>For Office Use Only</b>					
Height:		Weight:		BMI:	
Frame:	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L				