

Oregon Bariatric Center Program Application

DATE: _____

LAST NAME		FIRST	MI	MAIDEN
DATE OF BIRTH	GENDER: <input type="checkbox"/> Female <input type="checkbox"/> Male		RACE: <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			SOCIAL SECURITY NUMBER	
ADDRESS		CITY & STATE		ZIP
EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed				
OCCUPATION			EMPLOYER	
Can be reached or message left at HOME# during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No Home phone#:				
Can be reached or message left at WORK# during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No Work phone#:				
Can be reached or message left at CELL# during the day? <input type="checkbox"/> Yes <input type="checkbox"/> No Cell phone#:				
Do you wish to receive communication via E-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail:				
EMERGENCY CONTACT		RELATIONSHIP:		PHONE

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity. I understand that I am financially responsible for any balance not covered by the insurance carrier(s). I also request that payment of benefits from my policy _____ (Medigap/other) be paid directly to the billing entity until otherwise notified.

Signature

Signature of parent (if minor)

Patient Information

Name:
MRUN:
Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group
Oregon Bariatric Center Program Application
1 of 17

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME		
ADDRESS		
CITY	STATE	ZIP
POLICY HOLDER'S NAME	DOB	RELATIONSHIP TO PATIENT
POLICY NUMBER	GROUP/PLAN NUMBER	EFFECTIVE DATE
CUSTOMER SERVICE PHONE NUMBER	PROVIDER INQUIRY/PRE-CERTIFICATION PHONE NUMBER	
EMPLOYER PROVIDING MEDICAL INSURANCE		
IS GASTRIC BYPASS SURGERY AND/OR LAP-BAND FOR "MORBID OBESITY" A COVERED BENEFIT?		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

Please include a copy of your insurance criteria for Bariatric Surgery.

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME		
ADDRESS		
CITY	STATE	ZIP
POLICY HOLDER'S NAME	DOB	RELATIONSHIP TO PATIENT
POLICY NUMBER	GROUP/PLAN NUMBER	EFFECTIVE DATE
CUSTOMER SERVICE PHONE NUMBER	PROVIDER INQUIRY/PRE-CERTIFICATION PHONE NUMBER	
EMPLOYER PROVIDING MEDICAL INSURANCE		
IS GASTRIC BYPASS SURGERY AND/OR LAP-BAND FOR "MORBID OBESITY" A COVERED BENEFIT?		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

Patient Information

Name:
MRUN:
Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group
Oregon Bariatric Center Program Application
2 of 17

Please make a check in the box provided to show your answer.

1. Usually I Feel...



Very Badly
About Myself



Very Good
About Myself

2. I Enjoy Physical Activities...



Not At All



Very Much

3. I Have Satisfactory Social Contacts...



None



Very Many

4. I am Able to Work...



Not At All



Very Much

5. The Pleasure I get Out of Sex Is...



Not At All



Very Much

6. The Way I Approach Food Is...



I Live to Eat



I Eat to Live

Patient Information

Name:
MRUN:
Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group
Oregon Bariatric Center Program Application
4 of 17

CURRENT HEIGHT: _____ **CURRENT WEIGHT:** _____

WEIGHT HISTORY:

Please estimate as closely as possible for all that apply:

Life Event	Age	Weight
Middle School Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

DIET HISTORY:

Approximate age when you first seriously dieted: _____

List the diets and diet programs that you have tried:

Program	(Circle)	Date	Duration	MD Supervised?	Max Loss
Acupuncture	Yes / No				
Atkins	Yes / No				
Jenny Craig	Yes / No				
Monarch	Yes / No				
Nutri-Systems	Yes / No				
Optifast	Yes / No				
Overeaters Anonymous	Yes / No				
Weight Watchers	Yes / No				
T.O.P.S.	Yes / No				

List any weight loss medications that you have taken in the past:

List any other diets and/or weight loss methods you've tried:

List any physician-supervised weight loss attempts:

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

5 of 17

EATING AND EXERCISE HABITS

Are you on a diet at this time? Yes No If yes, what type diet or plan: _____

How long have you been following it? _____ How much weight have you lost on it? _____

Do you have any food allergies or intolerances? Yes No If yes, to what? _____

Do you take any vitamin or mineral supplements? Yes No If yes, what types and how often? _____

Do you follow any diet restrictions for other medical conditions (e.g. diabetes)? _____

Do you follow any religious or cultural food restrictions? _____

Are you vegetarian? Yes No If yes, how strictly do you avoid meat, fish and dairy products? _____

Are you opposed to eating a high protein diet? Yes No

How many meals do you eat in a typical day? _____ Which ones? (Breakfast/Lunch/Dinner)

Who does the cooking in your home? _____

Are you responsible for preparing meals for other people (e.g. children, spouse)? _____

Where do you usually eat your meals (e.g. at the table, in front of the TV)? _____

Do you ever eat in your car? Yes No If yes, how often? _____

Which of the following add the most extra calories to your diet? Check all that apply

_____ Convenience foods (e.g. frozen pizzas or dinners) Which types? _____

_____ Fast foods. How often and what do you typically order? _____

_____ Fried foods (e.g. chicken, French fries) Which types? _____

_____ Large portions. All foods or some thing(s) in particular? _____

_____ Salty foods (e.g. chips, crackers) Which are your favorites? _____

_____ Snacking. When and what types of foods do you snack on? _____

_____ Starchy foods (e.g. breads, pasta). Which types? _____

_____ Sweets (e.g. chocolate, ice cream) Which are your favorites? _____

_____ Other. Specify: _____

How often do you consume the following types of beverages?

	Types	How much and how often?
Alcoholic beverages		
Caffeinated beverages		
Fruit Juices and fruit drinks		
Other (e.g. Snapple, Sobe)		
Soda Pop		
Water		

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

6 of 17

Health Problems

CARDIOVASCULAR DISEASE:

Angina:

0. No chest pain
1. Chest pain only with intense activity (e.g. running, swimming)
2. Chest pain only with moderate activity (e.g. daily activities)
3. Chest pain with even minimal activity (e.g. walking across the room, resting)
4. Unstable angina
5. Unsure

Congestive Heart Failure:

0. No history of congestive heart failure
1. Symptoms only when exercising (Class 1)
2. Symptoms with ordinary daily activities (Class 2)
3. Symptoms even with minimal activity (Class 3)
4. Symptoms even when resting (Class 4)
5. Unsure

Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE):

0. No history of DVT or PE
1. DVT in the past resolved with blood thinning medication
2. Recurrent DVT on long-term blood thinner
3. Previous pulmonary embolism
4. Recurrent pulmonary embolism
5. Vena Cava filter
6. Unsure

High blood pressure (Hypertension):

0. No high blood pressure
1. Borderline, no medication
2. Diagnosed but treated with diet and exercise
3. On one high blood pressure medication. Medication taken: _____
4. On two or more blood pressure medications. Medications taken: _____
5. Poorly controlled even with medication

Heart Disease:

0. No heart disease
1. Abnormal heart testing (ECG, stress test) When? _____
2. History of heart attack. When? _____
3. History of stent or cardiac bypass surgery. When? _____
4. Unstable heart disease
5. Unsure or other _____

Leg edema (swelling, water retention in legs):

0. No leg edema
1. Occasional leg edema, no treatment needed
2. Symptoms require diuretics, elevation or compression stockings
3. Stasis ulcers
4. Disabling

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

8 of 17

Peripheral Vascular Disease (circulation problems)

- 0. None
- 1. Diagnosed but no symptoms (bruit present)
- 2. Claudication (pain, limping or weakness when walking), on blood thinning medication
- 3. History of TIA (Transient Ischemic Attack),
- 4. Surgery for PVD (bypass surgery of legs, endarterectomy)
- 5. History of stroke
- 6. Unsure

GASTROINTESTINAL:

Cholelithiasis (Gall Stones):

- 0. No history of gallstones
- 1. Gallstones present but no symptoms
- 2. Gallstones with occasional pain
- 3. Severe symptoms **or history of gallbladder removal**
- 4. Gallstones with severe symptoms requiring removal before bariatric surgery
- 5. Ongoing symptoms after gallbladder removal
- 6. Unsure

GERD (Reflux):

- 0. No reflux
- 1. Occasional reflux, no medication
- 2. Occasional medication. Medication taken & how often: _____
- 3. Use of H2 blockers or proton pump inhibitors such as Pepcid, Nexium, Prilosec or Tagamet
Medication(s) taken: _____
- 4. On double dose medication(s)
Medication(s) taken: _____
- 5. Anti-reflux surgery needed or prior history of surgery (e.g. Nissen Fundoplication)

Liver Disease:

- 0. No liver disease
- 1. Mildly enlarged liver (category 1)
- 2. Modestly enlarged liver (category 2)
- 3. Moderately enlarged liver (category 3)
- 4. Cirrhosis or NASH (non-alcoholic hepatitis)
- 5. Liver failure, transplant needed or have had transplant
- 6. Unsure or other _____

GENERAL:

Abdominal Hernia:

- 0. No abdominal hernia
- 1. Hernia present but no symptoms and no previous surgery
- 2. Abdominal hernia with symptoms
- 3. Successful abdominal hernia repair
- 4. Recurrent abdominal hernia
- 5. Longstanding hernia with complications or unsuccessful surgical repair
- 6. Unsure

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

9 of 17

Abdominal pannus (large apron of skin):

- 0. No pannus
- 1. Pannus present with skin irritation
- 2. Large pannus that it makes walking difficult
- 3. Pannus with skin infections or cellulitis
- 4. Pannus requiring surgery

Functional Status (Ability to walk):

- 0. Able to walk without difficulty
- 1. Able to walk 200 feet with an assistive device (cane, crutch, walker) Type of device(s) used: _____
- 2. Cannot walk 200 feet even with an assistive device
- 3. Wheelchair dependent
- 4. Bedridden

Pseudotumor Cerebri:

- 0. None
- 1. Symptoms include headaches with dizziness, nausea and/or pain behind the eyes
- 2. Symptoms include headaches with visual symptoms, controlled with diuretics
- 3. MRI has been done to confirm diagnosis
- 4. Controlled with medications stronger other than diuretics. Medication(s) taken: _____
- 5. Symptoms require narcotics to control, surgical intervention required

Stress Urinary Incontinence:

- 0. No leakage of urine
- 1. Occasional leaking with coughing, laughing or sneezing
- 2. Frequent leaking but not severe
- 3. Daily leaking, pad required
- 4. Disabling
- 5. Surgery performed but did not correct the problem

METABOLIC:

Glucose metabolism (Diabetes):

- 0. No diabetes
- 1. Elevated fasting glucose
- 2. Diabetes, on oral medication. Medication taken: _____
- 3. Diabetes, on insulin
- 4. Diabetes, on oral medication and insulin. Medications taken: _____
- 5. Diabetes with severe complications such as retinopathy, neuropathy, renal failure or blindness

Gout:

- 0. No gout
- 1. Elevated uric acid levels, no symptoms
- 2. Gout, on medication. Medication taken: _____
- 3. Gout with resulting joint disease
- 4. Gout with destruction of joints
- 5. Disabled due to gout, unable to walk

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

10 of 17

Hyperlipidemia (high cholesterol level):

- 0. Normal cholesterol level
- 1. High cholesterol, no treatment
- 2. High cholesterol treated with diet and exercise only
- 3. On one cholesterol lowering medication. Medication taken: _____
- 4. On two or more cholesterol lowering medications. Medications taken: _____
- 5. Uncontrolled even on medications

MUSCULOSKELETAL:

Back Pain:

- 0. No back pain
- 1. Occasional symptoms not requiring medicine or treatment
- 2. Symptoms requiring over the counter medication like Ibuprofen
- 3. Symptoms requiring narcotic treatment or degenerative changes on X-ray
Medication(s) taken: _____
- 4. Surgery done or surgery recommended after weight loss
- 5. Failed surgery, ongoing symptoms

Fibromyalgia:

- 0. No history of fibromyalgia
- 1. Treated with exercise
- 2. Treated with non-narcotic medications
- 3. Treated with narcotics
- 4. Surgery required
- 5. Disabling, treatment not effective

Musculoskeletal Problems (hip, knee, ankle and foot pain):

- 0. No symptoms
- 1. Pain with walking, no medication needed
- 2. Pain with walking, requiring over the counter medications. Medications taken: _____
- 3. Pain even when just walking around the house
- 4. Previous joint replacement or surgery
- 5. Disabling, awaiting joint replacement

PSYCHOSOCIAL:

Alcohol use:

- 0. None
- 1. Rarely (yearly)
- 2. Occasional (weekly to monthly)
- 3. Frequent (daily) Types of alcohol consumed: _____

Confirmed Mental Health diagnoses NOT including depression:

- 0. None
- 1. Bipolar disorder
- 2. Anxiety or panic disorder
- 3. Personality disorder
- 4. History of psychosis
- 5. Unsure or other _____

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

11 of 17

Depression:

- 0. No depression
- 1. Mild, occasional symptoms, no treatment
- 2. Moderate, may require treatment
- 3. Moderate, **taking antidepressant**. Medication(s) taken: _____
- 4. Severe, intensive treatment required
- 5. Severe, requiring hospitalization in the past

Substance Abuse (Prescription or Illegal drugs):

- 0. No history of drug abuse
- 1. History of drug abuse. Substance(s) used and when quit: _____
- 2. Currently using. What types and how often used: _____

Tobacco Use (current and former):

- 0. None. If former tobacco user, what type, how long used and when quit? _____
- 1. Rare
- 2. Occasional. What kind and how often? _____
- 3. Frequent. What kind and how often? _____

PULMONARY:

Asthma:

- 0. No asthma
- 1. Occasional symptoms, no medications needed
- 2. Symptoms controlled with inhaler. Type of inhaler used: _____
- 3. Well controlled but requires daily medication. Medication(s) taken: _____
- 4. Symptoms NOT well controlled and requiring steroids like Prednisone within last 2 years
- 5. Requiring emergency room visit or hospitalization within last 2 years

Obesity Hypoventilation Syndrome:

- 0. None
- 1. Hypoxemia (low blood oxygen) on room air
- 2. Severe hypoxemia (low blood oxygen)
- 3. Pulmonary hypertension
- 4. Right sided heart failure
- 5. Right sided heart failure with left ventricular dysfunction
- 6. Unsure

Obstructive Sleep Apnea:

- 0. No symptoms of sleep apnea
- 1. Sleep apnea symptoms but no test done yet
- 2. Sleep apnea diagnosed but no treatment
- 3. Sleep apnea, CPAP or BiPap required
- 4. Sleep apnea, Oxygen dependent
- 5. Sleep apnea with complications (e.g. pulmonary hypertension)
- 6. Unsure

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

12 of 17

Epworth Sleep Scale:

Complete this table if you have NOT already been diagnosed with sleep apnea

	0	1	2	3
How likely are you to doze or fall asleep in these situations?	Never Do	Slight Chance	Moderate Chance	High Chance
Sitting inactive in a public space (e.g. theatre, meeting)				
Sitting and resting				
Lying down to rest in the afternoon				
Watching Television				
Sitting and talking to someone				
Sitting quietly after lunch with no alcohol				
Passenger in a car for 1 hour without a break				

Sleep Apnea Risk Questionnaire:

Complete this table if you have NOT already been diagnosed with sleep apnea

	1	2	3	4
	Never	Rarely Less than once/week	Occasionally 1-3 times per week	Frequently More than 3 times/ week
How frequently do you experience or have you been told about snoring loud enough to disturb the sleep of others?				
How often have you been told that you have "pauses" in breathing or stop breathing during sleep?				

OFFICE USE ONLY TOTAL: ____/29

Pulmonary Hypertension:

- 0. Not present
- 1. Symptoms of tiredness, shortness of breath, dizziness, fainting
- 2. Confirmed diagnosis of pulmonary hypertension
- 3. Controlled with blood thinning medication and/or calcium channel blockers such as _____
- 4. Oxygen required
- 5. Lung transplant needed or have had in the past

REPRODUCTIVE:

Menstrual Irregularities (NOT due to polycystic ovarian syndrome):

- 0. No history of menstrual irregularities
- 1. Irregular or infrequent periods
- 2. Heavy bleeding during periods
- 3. Absence of periods (NOT due to menopause or hysterectomy)
- 4. Prior hysterectomy or menopause

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

13 of 17

Polycystic Ovarian Syndrome:

- 0. None
- 1. Symptoms present but no treatment
- 2. Treated with birth control pills
- 3. Treated with Metformin
- 4. Treated with two or more medications. Medication taken: _____
- 5. Infertile

Other Medical History not listed above:

- Bleeding abnormality. Explain: _____
- Blood transfusion
- Hepatitis. Type? _____
- Inflammatory Bowel Disease (Crohn's, ulcerative colitis)
- Kidney Disease. Explain: _____
- Thyroid Problems Explain: _____
- Other: _____

Please list below all serious illnesses, injuries and hospitalizations you have experienced in adulthood:

<u>Major Illness or injury</u>	<u>Date</u>	<u>Treatment</u>

Past Surgical History:

- Anti-reflux procedure (other than Nissen Fundoplication)
- Bowel resection
- Breast Biopsy
- Breast Cancer with mastectomy
- Breast Cancer with radiation
- CABG (Coronary Artery bypass grafting)
- Cholecystectomy, (gall bladder removal) Was it performed open or laparoscopically? _____
- Hip Replacement
- Hysterectomy with or without oophorectomy
- Knee replacement
- Laminectomy
- Nissen Fundoplication
- Peripheral Vascular procedure
- Tubal ligation
- Vagotomy
- Vasectomy
- Weight Loss Surgery. What type and when:** _____

Patient Information

Name:
 MRUN:
 Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group
Oregon Bariatric Center Program Application
 14 of 17

SOCIAL HISTORY:

Living Situation: _____

Who will be your primary support for surgery? _____

Have any of your friends had weight loss surgery: Yes No

HEALTHCARE:

Please list all the physicians from whom you receive medical care:

Type	Name	Address	Phone:
Primary Care Provider			
Referring Doctor (if different than above)			
Endocrinologist			
Orthopedist			
Psychologist			
Psychiatrist			
Other			

Have you seen any of the following PeaceHealth practitioners in the last 3 years?

- Dr. David White
- Camille Leider, FNP

Patient Information

Name:
MRUN:
Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group
Oregon Bariatric Center Program Application
16 of 17

SYSTEM REVIEW:

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. **CONSTITUTIONAL:** Excessive fatigue - exercise intolerance - fever - weakness - night sweats - general good health
2. **EYE:** blurry vision - double vision - haloes around lights - loss of night vision
3. **EAR, NOSE & THROAT:** stuffy Nose - runny Nose - hay fever - sinus trouble - earache - headaches - buzzing in ears - ringing in ears - discharge from ear - loss of hearing - dizziness - vertigo - loss of balance - sore throat - lump in throat - trouble swallowing - hoarseness
4. **RESPIRATORY:** cough - wheezing - shortness of breath at night - use of two pillows - blood in sputum - out of breath with exertion - wake up at night short of breath - wake at night coughing or choking - asthma - emphysema - bronchitis
5. **CARDIOVASCULAR:** palpitations - pounding heart - skipping heartbeat - pains in chest - pains in neck - pains in arms - squeezing of chest - heart attack - heart murmur - abnormal electrocardiogram - swelling - irregular heartbeat - high blood pressure - pain in legs - cold feet - blue toes - blue finger - loss of pulses
6. **GASTROINTESTINAL:** heartburn - nausea - vomiting - belching fluid in throat - burning in throat - food sticking in chest - pains in stomach - burning in stomach - acid stomach - diarrhea - constipation - pain with bowel movement - blood in stool - hemorrhoids - fissures - cramps - gassiness - irritable colon - colitis - change of bowel habits
7. **GENITOURINARY:** pain with urination - trouble starting urine - trouble stopping urine - small urine stream - blood in urine - kidney stones - bladder stones - kidney failure - nephritis - urinary tract infections - frequent urination - getting up at night to urinate - leakage of urine with cough or sneeze
 - Men: discharge from penis - loss of erection - painful erection
 - Women: vaginal discharge - vaginal bleeding - pain with intercourse - irregular periods
8. **ENDOCRINE (GLANDULAR):** low thyroid - hyperthyroid - goiter - Grave's Disease - thyroid nodules - x-ray to thyroid - diabetes - adrenal gland tumor - frequent flushing - frequent heavy sweating
9. **MUSCULOSKELETAL:** pain in joints - swelling of joints - redness of skin over joints - warm joints - fluid in joints - arthritis - broken bones - sprains - low back pain - hip pain - knee pain - ankle pain - foot pain - flat feet - slipped disk - herniated disk - sciatica
10. **NEUROLOGICAL:** dizziness - vertigo - falling to the side - falling at night - numbness - tingling - pins and needles feelings - weakness of any muscles - twitching of muscles - weakness of grip - shakiness - tremors - fainting - convulsions - fits - loss of consciousness
11. **PSYCHOLOGICAL:** nervousness - anxiety - depression - thoughts of suicide - suicide attempts - hospitalization for emotional problems - psychiatric treatment - psychological counseling

Oregon Bariatric Center Staff Signature

EMR #

Date

Time

Patient Information

Name:

MRUN:

Date:

Form # ____ OBC web / Forms / Program Application (8'11'09)

PeaceHealth Medical Group

Oregon Bariatric Center Program Application

17 of 17