BAPTIST HEALTH®
LEXINGTON

Patient Information Packet

Preferred Procedure:
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ Laparoscopic Greater Curvature Plication (LGCP)
- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Orbera Balloon

Revision-Previous Weight Loss Surgery
Original surgery:_____
Revision to
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ Apollo OverStitch-Previous Roux-en-Y Gastric Bypass
- ❍ SIPS

Surgeon: G. Derek Weiss, MD or Paige Quintero, MD
Program: Baptist Health Lexington, formerly Central Baptist Hospital / Baptist Physician Surgery Center - Lexington, Kentucky

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require:_____

Patient Information:

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____Patient's level of Education:_____

What is your height?_____ft _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

OK to leave message at: ❍ Home ❍ Work ❍ Cell

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ❍ Yes ❍ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?_____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?_____Relationship to you?_____

Spouse Information:

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information: – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance:

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance:

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact:

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Bluegrass Bariatrics to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s)":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician:

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

Have you discussed Weight Loss Surgery with your physician? ❍ Yes ❍ No is your physician supportive? ❍ Yes ❍ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Social Media
☐ Other (Please List):_____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

Blood Consent:

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Weight Loss History:

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet?_____lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ **NONE**

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System	❍ Overeaters Anonymous	❍ Weight Watchers	❍ Jenny Craig
❍ TOPS	❍ Optifast	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_____	

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol
❍ Redux	❍ Byetta	❍ Plegine	❍ Sanorex	❍ Meridia
❍ Xenical	❍ Diuretics	❍ Pondimin	❍ Phenteramine	
❍ Fen-Phen, # of months:_____		❍ Other:_____		

Behavioral Treatments for Weight Loss: ❍ **NONE**

❍ Hospitalization ❍ Hypnosis

❍ Physical Therapy ❍ Psychological Therapy

❍ Residential Programs ❍ Other:_____

Exercise: ❍ **NONE**

❍ Walking or Running ❍ Stationary cycle or treadmill

❍ Swimming ❍ Weight Training

❍ Team Sports ❍ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

●If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

●If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness ❍ Makes me happy ❍ Bored

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

Please tell us how your weight is interfering with your health and life? _____

_____

Why are you seeking weight loss surgery? _____

_____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

_____

_____

What is your greatest fear regarding surgery?_____

Medical History/Review of Symptoms: (Check all that apply)

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:_____	

Head and Neck:	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:_____

Cardiovascular:	☐ **NONE**	
☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Dyspnea on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:_____

Respiratory:	☐ **NONE**	
☐ Asthma	☐ Emphysema / COPD	☐ Bronchitis
☐ Pneumonia	☐ Chronic Cough	☐ Shortness of Breath at Rest
☐ Use of Cpap / Bipap	☐ Use of Oxygen	☐ Snoring
☐ Pulmonary Embolism	☐ Sleep Apnea	☐ Other:_____

Gastrointestinal:	☐ **NONE**	
☐ Heartburn	☐ Hiatal Hernia	☐ Ulcers
☐ Diarrhea	☐ Blood in Stool	☐ History of Liver Enzymes
☐ Constipation	☐ IBS	☐ Umbilical Hernia
☐ Difficulty Swallowing	☐ Hemorrhoids	☐ Fissure / Polyps
☐ Rectal Bleeding	☐ Black, Tarry Stool	☐ Ventral Hernia
☐ Abdominal Pain	☐ Enlarged Liver	☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems	☐ Jaundice	☐ Pancreatic Disease
☐ Nausea / Vomiting	☐ GERD	☐ Incisional Hernia
☐ Barrett's Esophagus	☐ Other:_____	

Bladder/Kidney:	☐ **NONE**	
☐ Kidney Stones	☐ Blood in Urine	☐ Prostate Problems
☐ Kidney Failure / Renal Insufficiency	☐ Leaking urine w/ cough/laugh/sneezing	☐ Men: PSA test in last year?
☐ Trouble starting urine	☐ Burning / Pain on urination	☐ Urinary Urgency/Frequency
☐ Overall Loss of Bladder Control	☐ Other:_____	

Gynecologic: (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post Menopausal

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast: ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram:_____

Musculoskeletal: ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Other:_____

Neurologic: ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudotumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ("manic-depression") ☐ Seen a Psychiatrist or Counselor

☐ Alcoholism / Substance Abuse ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attention Deficit Disorder ☐ Other:_____

Endocrine: ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ Other:_____

Blood/Lymphatic: ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Other:_____

Skin: ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing

☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea

☐ Hair or Nail Changes ☐ Other:_____

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	**Taken for what purpose:**	**Dosage/How Often:**

Allergies: ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

Foods (List foods and the reaction):_____

Surgical Procedure(s):	☐ **NONE**	**Year**		**Year**
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____
Hernia: ❍ Hiatal	❍ Umbilical	_____	Back:_____	_____
Tubal Ligation		_____	Knee: ❍ Right ❍ Left	_____
Cesarean Section		_____	Breast Biopsy: ❍ Right ❍ Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Colostomy		_____	Kidney Surgery	_____
Colon Resection		_____	Other:_____	_____
Endoscopy		_____	Other:_____	_____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____ ❍ Estimated ❍ Actual

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea	❍ Heart Stopped	❍ Woke up during procedure
❍ Vomiting	❍ Stopped Breathing	❍ Other:_____
❍ Difficulty Waking Up	❍ Difficulty Urinating	

Social History:

Do you smoke now?	❍ Yes ❍ No	If yes, how many packs per day?_____
Have you smoked in the past?	❍ Yes ❍ No	If you have quit, how many years since?_____
For how many years did you use tobacco?	_____Years	
Do you use snuff or chew?	❍ Yes ❍ No	If yes, how frequently do you use?_____
Do you consume alcohol now?	❍ Yes ❍ No	
If yes, how many times per week?	_____	If yes, how many drinks each time?_____
For how many years do/did you drink alcohol?	_____Years	
Is anyone concerned about the amount you drink?	❍ Yes ❍ No	If you have quit, how many years since?_____
Do you use street drugs now?	❍ Yes ❍ No	If yes, what drugs?_____
If yes, how frequently do you use these drugs?	_____	If you have quit, how many years since?_____

How many hours a day do you watch TV? ❍ Never ❍ Rarely ❍ 3-5 hours ❍ 5+ hours

What hobbies do you have that are important to you? _____

Could someone help care for you if you were seriously ill? ❍ Yes ❍ No Who?_____

Are there people for whom you are the primary care giver? ❍ Yes ❍ No Who?_____

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life.

Married Life? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Present job/activities? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Overall satisfaction with yourself? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before sending in your packet:

- ☐ Filled out this form completely
- ☐ Made a copy of the front and back of your insurance card
- ☐ Signed the Blood Consent
- ☐ Called your insurance and completely fill out the Insurance Review Form

Date Completed: _____

Mail completed packet and Insurance Card to:

BHMG-Bariatric Surgery
2716 Old Rosebud Road, St. 350
Lexington, Kentucky 40509

Fax: 859-543-1637

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. **Do not leave any fields blank.**
5. **Sign the form on the back. Failure to do so will result in the form being returned.**
6. Once complete, return this form, along with a copy of your insurance card(s), to our office.
7. Please also make sure that you submit your patient profile packet via mail or internet.
8. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
    a. Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. **You must complete this form if you have a Medicare supplement plan, Medicare Replacement plan, or a Medicare HMO.**

Fill in this information before you call the insurance company. Please write clearly.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	□ **Yes** (Continue with this form.) □ **No** (Complete #s 2, 23, 25 & 27-29 then end the call.) **See explanation below
****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3	Do I have a Bariatric Lifetime Max?	
4	Am I required to have Weight Loss Surgery at a Center of Excellence facility or Blue Distinction Center?	**Center of Excellence:** □ **Yes** □ **No** **Blue Distinction:** □ **Yes** □ **No**
5	Is **BHMG-Bariatric Surgery** in my network?	
6	Is Baptist Physician Surgery Center in my network? Tax ID #: 043665929	
7	Is Baptist Health Lexington in my network? Tax ID #: 610444707	

8	What is the effective date of my policy?	
9	What is the calendar year renewal date?	
10	Do I have a pre-existing clause?	
11	If yes, what is the end date of the pre-existing clause?	
12	Is a referral required?	
13	What is the deductible per calendar year?	
14	How much have I met towards my deductible?	
15	What is the maximum out of pocket per calendar year?	
16	How much have I met towards my maximum out of pocket?	
17	Is the deductible applied to the maximum out of pocket?	
18	What is the co-insurance percent for my policy?	
19	What are my financial obligations to the doctor for inpatient surgery?	
20	What are my financial obligations to the doctor for outpatient surgery?	
21	What are my financial obligations to the hospital for inpatient surgery?	
22	What are my financial obligations to the hospital for outpatient surgery?	
23	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
24	What is my copay for a primary care office visit?	
25	What is my copay for a specialist office visit?	
26	What is the fax number for pre-determination?	
27	Name of the representative	
28	Date you spoke to representative	
29	**If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.**	**□ Yes** **□ No**

Disclaimer:

- **BHMG-Bariatric Surgery** is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by **BHMG-Bariatric Surgery**.

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**
- **I have read and understand the disclaimer which includes that I am not approved for surgery.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

Patient Signature: _____ **Date:** _____