BAPTIST HEALTH®
MEDICAL GROUP

Baptist Health Medical Group- Bariatric Surgery

Welcome to Baptist Health Medical Group. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are several steps leading to bariatric surgery, we have developed a multidisciplinary team to help you. It is very important that you take an active role during this process. Your efforts will ensure the process moves as efficiently as possible.

To provide you with the best possible service, we must have the following information before scheduling your initial intake appointment.

Send or bring the following to Baptist Health Medical Group Bariatric Surgery:

- New Patient Paperwork Packet
- Certificate of benefits for your current insurance plan(s). This can be obtained by calling your insurance company and requesting it or logging into your insurance patient portal.
    - If you have a Medicaid or Medicare policy, you may skip this step.
- Insurance and Prescription Cards: Include copies of all cards, front and back
- Photo ID: front and back

Baptist Health Medical Group Bariatric Surgery
2125 State Street Ste 1
New Albany IN 47150

Phone Number: 812-949-7151
Fax Number: 812-949-7191
Email: BHMGBariatrics@BHSI.com

What Happens Next?

Once you complete and return the above required items, your information will be reviewed to ensure you meet criteria for surgery. You should hear from our office within 2 weeks of our office receiving your information.

Please note when submitting your packet, you must return it with a LEGIBLE COPY OF YOUR INSURANCE CARD(S) FRONT AND BACK (INCLUDING PRESCRIPTION CARD if applicable), PHOTO ID AND A COPY OF YOUR CERTIFICATE OF COVERAGE/SUMMARY OF BENEFITS STATING BARIATRIC SURGERY IS COVERED ON YOUR CURRENT INSURANCE PLAN. Failure to do this could cause a hold to be put on your packet until all items have been received.

During your first visit, plan to be at the office for 3-4 hours. All patients will attend an educational class. You will also meet with our surgeon to review your history and answer surgical questions, meet with our registered dietician for nutritional screening and a Psychologist. You may get started on the following items, but they are not necessary to complete before your first visit. Insurance companies may require participation in a medical weight management program before surgery is approved. In order to best prepare patients for a new post-surgery lifestyle, Baptist Health Medical Group Bariatric Surgery can provide this service to our patients.

However, you may see your primary care physician monthly to fulfill the requirement specified by your insurance plan. Our office can provide the forms that include insurance requirements. Each monthly visit must include; height, weight and goals for a diet and exercise plan.

Please note that pre-authorization is not a guarantee of payment. Medical necessity of the services will be determined by insurance before they are provided.
Some insurance polices have contract exclusions which mean that bariatric surgery will not be paid for even if it is medically necessary. Self-pay information is available calling our office at 812-949-7151.

Thank you for the opportunity to provide you with care.

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Patient Information Packet

Preferred Procedure:

- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Laparoscopic Sleeve Gastrectomy

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 accommodation that you require: _____

Patient Information

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

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

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

Address Information:

Street Address:_____

City:_____State:_____ Zip Code: _____

Email Address: _____

Phone (home):_____ Phone (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

Spouse Information

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

Spouse's Cell Phone: _____Spouse's SSN: _____

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

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Employer's address: _____

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:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____Phone:_____

Primary/Referring Physician

First Name:_____ Last Name:_____

Street Address:_____

City:_____State:_____ Zip Code:_____Phone:_____

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
☐ Stillman Diet	☐ Mayo Clinic	☐ Fasting	☐ Low Carbohydrate
☐ Gloria Marshall	☐ Herbal Life	☐ Calorie Counting	☐ Scarsdale
☐ Richard Simmons	☐ Sugar Busters	☐ Atkin's Diet	☐ Slim Fast

☐ 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

☐ Other:_____

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

General: ☐ **NONE**

☐ Fevers ☐ Weight Gain ☐ Tired / No Energy

☐ Insomnia ☐ Hair Loss ☐ Other:____

Head and Neck ☐ **NONE**

☐ Vision Problems ☐ Hearing Problems ☐ Hoarseness

☐ Dentures, Partial / Full ☐ Other:____

Cardiovascular ☐ **NONE**

☐ Heart Attack ☐ Chest Pain w/ Activity ☐ Rhythm Changes

☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Palpitations

☐ Varicose Veins ☐ Shortness of Breath 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

☐ Chronic Pneumonia ☐ Chronic Cough ☐ Shortness of Breath at Rest

☐ Use of CPAP / BiPAP ☐ Use of Oxygen ☐ Snoring

☐ Pulmonary Embolism ☐ Sleep Apnea ☐ Had a sleep study; when:_____

Gastrointestinal ☐ **NONE**

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers

☐ Diarrhea ☐ Blood in Stool ☐ History of elevated Liver Enzymes

☐ Constipation ☐ IBS (irritable bowel syndrome) ☐ Umbilical Hernia

☐ Difficulty Swallowing ☐ Hemorrhoids

☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia

☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis

☐ Current Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease

☐ Chronic Nausea / Vomiting ☐ GERD ☐ Incisional Hernia

☐ Barrett's Esophagus ☐ N A F L D / N A S H ☐ Other: _____

Bladder/Kidney ☐ NONE

☐ Kidney Stones

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing

☐ Urinary Urgency/Frequency ☐ Other: _____

Gynecologic (for women only) ☐ NONE

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

☐ PCOS ☐ Menstrual Irregularity

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

How many pregnancies have you had:_____

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

Musculoskeletal ☐ NONE

☐ Lupus • Joint Pain

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Osteoarthritis ☐ Other: _____

Neurologic ☐ NONE

☐ Balance Disturbance ☐ Dizziness ☐ Weakness

☐ Stroke ☐ Seizures or convulsions ☐ Multiple Sclerosis

☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Numbness / Tingling

☐ Other:_____

Psychiatric ☐ NONE **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**
If yes, please provide name & phone number: _____

☐ Depression/Anxiety ☐ Borderline Personality Disorder

☐ Bipolar Disorder ("manic-depression") ☐ Dissociative Identity Disorder (Multiple personality)

☐ Schizophrenia / Schizoaffective Disorder

☐ Been hospitalized for psychiatric problems *(if within 12 months- date of hospitalization*) _____

☐ Attention Deficit Disorder

☐ Alcoholism / Substance Abuse - Sobriety Date: _____ ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attempted Suicide- Date: _____

☐ Been in chemical dependency program- Clean Date: _____

☐ Currently taking medications for psychiatric problems or for depression

☐ Other: _____

Endocrine ☐ NONE

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ Diabetes ☐ Gout ☐ Excessive Urination

☐ Other: _____

Blood/Lymphatic ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS
☐ Lymphoma ☐ Swollen Lymph Nodes ☐ History of DVT / PE
☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use • Other: _____

List Prescribed Medications: **Taken for what condition:** **Dosage/How Often:**

☐ **Please attach list of medications if easier**

☐ **NONE**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Current Pharmacy: **Address:** **Phone #**

_____ _____ _____

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**
Appendectomy	_____	Gallbladder	_____
Hysterectomy	_____	Heart surgery: CABG/Stents	_____
Valve Replacement	_____	Pacemaker	_____
Hernia: ☐ Hiatal ☐ Inguinal ☐ Incisional ☐ Umbilical			
Tubal Ligation	_____	Knee: ☐ Right ☐ Left	_____
Cesarean Section	_____	Breast Biopsy: ☐ Right ☐ Left	_____
Colonoscopy	_____	Anti-reflux procedure / Nissen Fundoplication	_____
Hemorrhoidectomy	_____		
Colon Resection	_____	Back:_____	_____
Endoscopy/EGD	_____	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 Name: _____

List any complications of weight loss surgery:

_____

Original Weight prior to surgery: _____ Estimated / Actual

Lowest Weight Achieved: _____ Estimated / Actual

Social History

Do you currently smoke/ vape/ chew/ dip? YES NO

Have you in the past? YES NO

For how many years did you use tobacco/ nicotine products? _____ Years

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

Do you use street drugs now? YES NO If yes, what drugs? _____

If yes, how frequently do you use these drugs? _____

Have you used street drugs in the past? YES NO If yes, Quite Date? _____

Thank you 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 packet as completely as possible
☐ Made a copy of the front and back of your insurance card(s)
☐ Copy of personal ID
☐ Certificate of benefits from current insurance policy(s) – not needed for Medicare/Medicaid policies

If you have an exclusion in your policy, would you like to self-pay for surgery. Please circle Yes or No

Send all of the above items to one of the following:

- **Mail: Baptist Health Floyd Bariatrics**
  2125 State Street Ste 1
  New Albany, IN. 47150

- **Fax: (812) 949-7191**

- **Email: BHMGBARIATRICS@BHSI.COM**

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 Baptist Health Medical Group- Bariatric.

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.

Patient Signature: _____ Date: _____