**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 up to bariatric surgery, so 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.

In order to provide you with the best possible service, we must have the following information on file 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: this can be obtained by calling your insurance and requesting it or logging into your insurance patient portal.
-If you have a Medicaid or original 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
950 Breckenridge Lane, Suite 10
Louisville, KY 40207

Fax: 502-894-9595
Email: BHMGLouBariatrics@BHSI.com

---

**What Happens Next?**

**Surgical Program:**

Once you Complete and return your packet and certificate of benefits, your information will be reviewed to ensure you meet criteria for surgery. You should hear from our office within 2 weeks of submitting your packet.

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. You will see a Nurse Practitioner for a History and Physical, a Registered Dietician for a 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 the insurance requirements. Each monthly visit must include; height, weight and goals for a diet and exercise plan.

**Diet programs (Weight Watchers®, Jenny Craig®, etc.) typically do not meet this requirement.

Many insurance companies require daily food and exercise logs. You may consider beginning these as soon as possible.
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 policies have contract exclusions which mean that weight loss surgery will not be paid for even if it is medically necessary. Self-pay information is available by request. If you have questions regarding your insurance, please contact our office at, (502)894-9499.

**Medical Weight Loss Program:**

Once you complete and return your packet, your information will then be reviewed to ensure you meet criteria for Medical Weight Loss. You should hear from our office within 2 weeks of submitting your packet.

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 DETERMINATION OF BENEFITS QUESTIONNAIRE REVIEWING COVERAGE FOR ANTI-OBESITY MEDICATIONS. Failure to do this could cause a hold to be put on your packet until all items have been received.

Our Medical Weight Loss Program consists of 7 visits, in which you will see a variation of providers within our Multi-Disciplinary Program. During your first visit, you will meet with one of our Nurse Practitioners to establish care, discuss goals and expectations for the program. After this appointment, you will have scheduled follow ups with a bariatric provider for 6 consecutive months. This is to evaluate progress towards your specific goals as well as give support and guidance in finding a sustainable routine to manage long term health. On an individual basis we will establish candidacy for weight loss medication use.

**Baptist Health Medical Group – Bariatric Surgery**

For any questions regarding insurance concerns or for questions related to medical concerns, test results, surgical scheduling etc.; please call our office at 502-894-9499.
If you or your healthcare team are wanting to send documentation to our office, the fax number is 502-894-9595.

Thank you for the opportunity to provide you with care.

**Baptist Health Medical Group-Bariatric**

# Patient Information Packet

**Please see page 10 for how to return packet to the office**

**Which Program are you interested in?**

- ○ Surgical Program
- ○ Medical Weight Loss Program

**For Surgical Program ONLY:**

**Preferred Procedure:**

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ 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 accommodations 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:_____

E-mail:_____ Phone (home):_____

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

**Primary Care Provider Information:**

Provider Name: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Office phone number:_____

**Patient Employment Information:**

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 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:_____

**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:_____

**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 weight?_____

How long did you sustain 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 |
| ❍ Low Carb | ❍ Stillman Diet | ❍ Mayo Clinic | ❍ Fasting |
| ❍ Gloria Marshall | ❍ Herbal Life | ❍ Calorie Counting | ❍ Scarsdale |
| ❍ Richard Simmons | ❍ Sugar Busters | ❍ Atkin's Diet | ❍ Slim Fast |

**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:_____ | | |

**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 large meals? (gorge) | ❍ Yes ❍ No |
| Eat a lot of sweets? | ❍ Yes | ❍ No | Drink carbonated beverages? | ❍ Yes ❍ No |
| Drink soda pop. | ❍ Yes | ❍ No ❍ Diet ❍ Regular | | |

**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 | ☐ Dyspnea on Exertion | ☐ Ankle Swelling |
| ☐ Ankle / Leg Ulcers | ☐ Elevated Triglycerides | ☐ Phlebitis / DVT |
| ☐ Clogged Heart Arteries | ☐ Rheumatic Fever / Valve Damage / MVP | ☐ Rapid Heartbeat |
| ☐ Irregular Heartbeat | ☐ 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 ☐ Other:_____

**Gastrointestinal** ☐ **NONE**

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers

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

☐ Constipation ☐ IBS ☐ Umbilical Hernia

☐ Difficulty Swallowing ☐ Hemorrhoids · Barrett's Esophagus

☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia

☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis

☐ Current Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease

☐ Nausea / Vomiting ☐ GERD ☐ Incisional Hernia

☐ Other:_____

**Bladder/Kidney** ☐ **NONE**

☐ Kidney Stones

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

☐ Trouble starting urine ☐ Urinary Urgency/Frequency

☐ Other:_____

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

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

☐ PCOS ☐ Menstrual Irregularity · Post Menopausal

☐ Excessively Heavy Periods ☐ Plan to have more children

How many pregnancies have you had:_____

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

**Musculoskeletal** ☐ **NONE**

☐ Lupus · Joint Pain · Rheumatoid Arthritis

☐ Muscle Pain / Spasm ☐ Sciatica · Osteoarthritis

☐ Fibromyalgia ☐ Other:_____

**Neurologic** ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ 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")
☐ Schizophrenia / Schizoaffective
· Been hospitalized for psychiatric problem
Hospitalization Date (if within past 12 months): _____
☐ Alcoholism / Substance Abuse
Sobriety Date: _____
☐ Attempted suicide
Date: _____
☐ Been in a chemical dependency program
Clean Date: _____
☐ Currently taking medications for psychiatric problems or for depression
☐ Other:_____

☐ Borderline Personality Disorder
☐ Dissociative Identity Disorder (Multiple Personality)
· Attention Deficit Disorder
· Victim of Mental/Emotional/Sexual/Physical Abuse
☐ Seen or seeing a psychiatrist or Counselor
Name of provider: _____

**Endocrine** ☐ **NONE**

☐ Parathyroid (hypo/hyper)
☐ Low Blood Sugar
☐ "Pre-Diabetes"
☐ Abnormal Facial Hair
☐ Hypothyroid
☐ Excessive Thirst
☐ Diabetes
☐ Excessive Urination
☐ Goiter
☐ Endocrine Gland Tumor
· Gout
☐ Other:_____

**Blood/Lymphatic** ☐ **NONE**

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

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

☐ **NONE** **Attach Home Med list if easier**

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

**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):_____

**Surgical History:**

- **NONE**

| **Procedures** | **Year** |
|---|---|
| **Gallbladder** | |
| **Appendectomy** | |
| **Hysterectomy** | |
| **Oophorectomy (Ovary Removal)** | |
| **Hernia**<br>○ **Hiatal**<br>○ **Inguinal**<br>○ **Incisional**<br>○ **Umbilical** | |
| **Tubal Ligation** | |
| **Cesarean Section** | |
| **Colonoscopy** | |
| **Endoscopy/EGD** | |
| **Hemorrhoidectomy** | |
| **Colon Resection** | |
| **Heart Surgery (CABG/Stent)** | |
| **Valve Replacement** | |
| **Pacemaker** | |
| **Knee**<br>○ **Right**<br>○ **Left** | |
| **Breast Biopsy**<br>○ **Right**<br>○ **Left** | |
| **Anti-reflux procedure/ Nissen Fundoplication** | |
| **Back** | |
| **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

**Social History**

Do you currently smoke/ vape/ chew/ dip? ❍ Yes ❍ No

Have you in the past? ❍ Yes ❍ No Quit date?_____

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, Quit date? _____

**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 as completely as possible
- ☐ Made a copy of the front and back of your insurance Card
- Copy of ID

**If you have an exclusion in your policy, would you like to self-pay for surgery: Circle Yes or No**

**Send completed packet and Copy of Insurance Card to one of the following:**

- **Mail:** Baptist Health Medical Group- Bariatric
  950 Breckenridge Lane, Suite 10
  Louisville KY 40207
- **Fax:** (502)894-9595
- **Email:** BHMGLouBariatrics@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.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

**Patient Signature:** _____ **Date:** _____