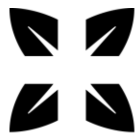

BAPTIST HEALTH®
MEDICAL GROUP

Patient Information Packet

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

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow

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):____________________

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, healthcare companion/caretaker, or anyone who makes your medical decisions?

☐ YES ☐ NO If yes, who?______________________________Relationship to you?______________

Do you have a living will? ☐ YES ☐ NO

Please provide the office with a copy of any legal documentation pertaining to the above questions.

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 Baptist Health Medical Group to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

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 ☐ Other:______________

Please list any specialists/ providers that you currently see: ☐ NONE

Name	Specialty	Address/phone

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/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/soda? ❍ Yes ❍ No

- If yes, how many cans/bottles per day?___________________

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/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?

____

____

____

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

____

____

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	☐ 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	☐ Bronchitis
☐ 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:__________
☐ Other:______________		

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	☐ 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	☐ N A F L D / N A S H	☐ 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?
☐ Overall Loss of Bladder Control
☐ Urinary Urgency/Frequency/Pain/Burning
☐ 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

Current method of birth control: ________________________________

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
☐ Osteoarthritis
☐ Other: _____________________________

Neurologic ☐ **NONE**

☐ Balance Disturbance
☐ Dizziness
☐ Restless Leg Syndrome
☐ Stroke
☐ Seizures or convulsions
☐ Weakness
☐ Knocked Unconscious
☐ Numbness / Tingling
☐ Multiple Sclerosis
☐ Pseudo tumor 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")
☐ Alcoholism / Substance Abuse ___ Past? ___ Present?
☐ Been in a chemical dependency program When: _________________
☐ Schizoaffective disorder
☐ Borderline Personality Disorder
☐ Hospitalized for psychiatric problems When:________
☐ Attempted suicide When: ______________________
☐ Experience Suicidal Ideation When: _____________
☐ Inflicted self-harm When: ______________________
☐ Victim of Mental/Emotional/Sexual/Physical Abuse
☐ 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

☐ PCOS ☐ 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:____

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

Procedure		Year	Procedure			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 ☐ Inguinal	☐ Incisional ☐ Umbilical					
Tubal Ligation		________	Knee:	☐ Right	☐ Left	________
Cesarean Section		________	Breast Biopsy:	☐ Right	☐ Left	________
Colonoscopy		________	Anti-reflux procedure / Nissen Fundoplication			________
Hemorrhoidectomy		________	Kidney Surgery:______________________			________
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: ______________________

List any complications of WLS: ______________________________

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

<u>Anesthesia Problems:</u> 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 have/had you drank 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?__________

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?__________

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							

Name of person completing packet: ______________________________

Relationship to patient: ______________________________

Signature of person completing packet: ______________________________

Signature of patient: ______________________________

Thank you for taking the time to complete the Patient Information Packet.
Please return this packet, a copy of your insurance card(s) front and back, a copy of your photo ID, and your completed insurance verification form to Baptist Health Medical Group Floyd Bariatrics. The office will start processing your information once received and will contact you within the next 30 days.

Determining Your Insurance Benefits

This form does not need to be completed for Medicare, Medicaid, Medicaid MCO's but it does need to be filled out for Medicare Replacement, Medicare HMO, and Medicare Supplements.

This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery, and to give you an idea of your out of pocket cost for surgery. Please follow the instructions below

Instructions:

1. 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.
2. Call the customer service number located on your insurance card and speak to a customer service representative.
3. Tell the representative that you would like to check policy benefits.
4. 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.
5. **Do not leave any fields blank.**
6. **Sign the form on the back. Failure to do so will result in the form being returned.**

7. Once complete, return this form, along with a copy of your insurance card(s), photo ID, and patient profile packet to our office.

Fill in this information before you call the insurance company. Please write clearly.	
atient Name	
atient Date of Birth	
surance Name	
) Number	
roup Number	
ubscriber Name	
ubscriber Date of Birth	

#	Questions for the Representative	Answer from the 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** (Skip #2, #3, and continue with this form.) **NO** (Complete #s 2, 3, 28, 29, 30 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.	What are the exclusions for surgical treatment of obesity?	
4.	Which procedures are covered? Laparoscopic Sleeve Gastrectomy (43775)? Laparoscopic Gastric Bypass (43644)?	
5.	Do I have a Bariatric Lifetime Maximum?	
6.	Am I required to have weight loss surgery at an accredited facility or specific hospital system?	
7.	If yes, what accreditation or hospital system?	
8.	Is Baptist Health medical Group-Bariatrics (Dr. Lanny Gore) in my network? Tax ID# 205497203	
9.	Is the facility in my network? Baptist Health Tax ID# 610444707	
10.	What is the effective date of my policy?	
11.	What is the calendar year renewal date?	
12.	Is a referral required?	
13.	Do I have a pre-existing clause?	
14.	If yes, what is the end date of the pre-existing clause?	
15.	What is the deductible per calendar year?	
16.	How much have I met towards my deductible?	
17.	What is the maximum out of pocket per calendar year?	
18.	How much have I met towards my maximum out of pocket?	
19.	Is the deductible applied to the maximum out of pocket?	
20.	What is the co-insurance percent for my policy?	

21.	What are my financial obligations to the doctor for inpatient surgery?	
22.	What are my financial obligations to the doctor for outpatient surgery?	
23.	What are my financial obligations to the hospital for inpatient surgery?	
24.	What are my financial obligations to the hospital for outpatient surgery?	
25.	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
26.	What is my copay for a specialists office visit?	
27.	What is the fax number for pre-determination?	
28.	Name of the representative	
29.	Date you spoke to representative	
30.	**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:

- Baptist Health Medical Group Floyd Bariatrics 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 Baptist Health Medical Group Floyd Bariatrics.

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:** ____________________