Center For SURGICAL WEIGHT LOSS
West Jefferson Medical Center™

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# BARIATRIC PATIENT INFORMATION PACKET

Patient Name: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____

Cell _____ Fax _____

Birth Date _____ Social Security Number _____

Gender (M, F) Marital Status (M, S, D, W) _____

Email Address _____Pharmacy of choice _____

## EMERGENCY CONTACT

Name _____ Phone # _____

Relationship _____

## PATIENT'S EMPLOYMENT

Employer _____

Position _____

Phone # _____

## INSURANCE INFORMATION

Insurance Company _____

Name of Insured _____

Relationship _____ D.O.B _____

ID or Member # _____ Group # _____

Customer Service Contact # _____

**Who Referred You To Us? _____**

## PHYSICIAN INFORMATION

Primary Care Physician _____

Phone # _____ Fax _____

Cardiologist _____

Phone # _____ Fax _____

Gynecologist _____

Phone # _____ Fax _____

Other Physicians _____

Phone # _____ Fax _____

**Do You Have A Referral / Letter Of Medical Necessity From Your Doctor?**

Yes Or No

## DIET INFORMATION

Height _____ Weight _____

Lowest Weight Last Five Years _____ Lbs

Highest Weight Last Five Years _____ Lbs

List Any Physicians That Treated You for Weight Loss

Name _____ Dates _____

Name _____ Dates _____

**PLEASE MARK ANY OF THE DIET METHODS YOU TRIED AND HOW MUCH WEIGHT YOU LOST.**

Adkins _____ Lbs Southbeach _____ Lbs Jenny Craig _____ Lbs

Weight Watchers _____ Lbs Nutri-System _____ Lbs Adipex _____ Lbs

Aspen Clinic _____ Lbs Metabolife _____ Lbs Other _____

**List Any Other Programs You Have Tried:**

_____
_____
_____
_____

## PERSONAL MEDICAL CONDITIONS

__ Diabetes
__ Hypertension
__ Sleep Apnea
__ Blood Clots/ DVT/ PE
__ Asthma
__ Heart attack/CHF/A Fib
__ Stroke
__ Bleeding problems
__Cirrhosis/ hepatitis
__ Acid reflux/Hiatal hernia
__ Cancer Type _____
__ High Cholesterol
__ Arthritis Knees/Hips/Ankles
__ Ruptured Disc/ Back pain
__ PVD/Poor circulation
__ Kidney disease
__ Stomach ulcer
__ Gallstones
__ Pancreatitis
__ Ulcerative colitis/ Crohns
__ Thyroid disease
__ Anxiety/ Depression
__ Mental Illness

**List any other medical problem not listed above**

_____
_____
_____

## MEDICATIONS

| Medication | Dosage | Medical Condition |
|---|---|---|
| | | |

## ALLERGIES

Medication_____ Reaction _____

Medication_____ Reaction _____

## SURGICAL HISTORY

__ Lysis of Adhesions __ Hernia __ Gallbladder __ Stomach/ Ulcer

__ Colon __ Pancreas __ Spleen __ Hiatal Hernia/ Nissen

__ Esophagus __ Appendix __ Uterus/ Hysterectomy/ Ovaries

__ C-Section __ Trauma __ Tubal Ligation __ Laparoscopy

__ Heart Surgery __ Lung __ Orthopedic __ Bariatric Surgery

**Please list dates and details:**

_____
_____
_____
_____
_____

## FAMILY HISTORY

| | MOTHER | FATHER |
|---|---|---|
| Heart Disease | _____ | _____ |
| Diabetes | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Stroke | _____ | _____ |
| Cancer | _____ | _____ |
| Blood Clots | _____ | _____ |
| Heart Disease | _____ | _____ |
| Bleeding Problems | _____ | _____ |
| Kidney Disease | _____ | _____ |
| Thyroid Disease | _____ | _____ |
| Obesity | _____ | _____ |

## SOCIAL HISTORY

Occupation _____

Do you drink Alcohol? _____ How Much? _____

Do you smoke? _____ How Much? _____

When we provide medical care for you, we automatically share appropriate medical information about you with your regular physician and other providers who treat you. We also send the necessary information to your health insurance plan so they can pay for your care.

When appropriate—like in worker's compensation cases—we must give appropriate information to your employer.

Now, effective April 14, 2003, a new law (HIPAA) requires us to have your permission to share your confidential medical information or "Protected Health Information (PHI)" with anyone else—even, for example, family members. So please complete the form below:

○ I authorize my physician and/or administrative and clinical staff to use my Protective Health Information (PHI) and to disclose it as specified below* to the following persons or entities:

**EXAMPLE: MOTHER, FATHER, HUSBAND, WIFE, SON, DAUGHTER, ETC……**

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |

*This authorization permits my physician to use and disclose the following individually identifiable health information (PHI) about me:

SELECT ONLY ONE: 1. **Any and all** protected health information.
2. O**nly the following** protected health information.

IF YOU SELECTED "2", COMPLETE THE FOLLOWING—OTHERWISE CONTINUED ON THE NEXT PAGE

○Specific Information to be disclosed:

_____
_____
_____

This limited information is being used or disclosed for the following purposes:

_____
_____
_____

If information is requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) are provided so we can make an informed decision whether to allow release of the information.

○**This authorization (Please check only one):**

☐ **Is PERMANENT unless I revoke it in writing**
☐ **Will EXPIRE in one year**
☐ **Will EXPIRE in _____months**
☐ **Will EXPIRE _____ (specify event, such as "when released from doctor's care")**

- ○ I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at **1111 Medical Center Blvd. Suite S-860, Marrero, LA 70072.** I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

- ○ I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

- ○ I do not have to sign this authorization in order to receive treatment from this practice. In fact, I have the right to refuse to sign this authorization unless my treatment is for **research purposes** or to **determine benefits** or **employment status.**

- ○ I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

**I hereby authorize the above listed insurance companies to pay directly to SURGICAL CLINIC OF LOUISIANA benefits due me, if any, as provided in the above un-expired policy. I will pay all charges in excess of whatever sums may be paid. I authorize SURGICAL CLINIC OF LOUISIANA to release information to the insurance company for my claims to be paid.**

**CONSENT TO TREATMENT: I hereby authorize my physician and whomever he/she may designate as his/her assistant or consultant to render medical treatment to me. I consent to any medical care which encompasses laboratory, diagnostic or medical treatment which my physician or his/her assistant or consultant deem necessary.**

_____ _____

Signature Date