



[www.sclaweightloss.com](http://www.sclaweightloss.com)

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## Bariatric Surgery Patient Information Packet

Please complete the following patient information packet and mail or fax to our office with a copy of your insurance card (**front and back**). Our office will contact you when it is received.

PATIENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

CELLULAR (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

GENDER (M, F) \_\_\_\_\_ MARITAL STATUS (M, S, D, W) \_\_\_\_\_

EMAIL \_\_\_\_\_

### EMERGENCY CONTACT

NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

### PATIENT'S EMPLOYMENT

EMPLOYER \_\_\_\_\_

POSITION \_\_\_\_\_

PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

INSURED SSN# \_\_\_\_\_ GROUP # INSURED \_\_\_\_\_

CUSTOMER SERVICE CONTACT # \_\_\_\_\_ ID OR MEMBER# \_\_\_\_\_

**WHO REFERRED YOU TO US?** \_\_\_\_\_

**PHYSICIAN INFORMATION**

FAMILY PHYSICIAN \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

CARDIOLOGIST \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

GYNOCOLOGIST \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

OTHER PHYSICIANS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

**DO YOU HAVE A REFERRAL / LETTER OF MEDICAL NECESSITY FROM YOU DOCTOR?**

YES OR NO

**DIET INFORMATION**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_ (OFFICE USE ONLY)

LOWEST WEIGHT LAST FIVE YEARS \_\_\_\_\_

HIGHEST WEIGHT LAST FIVE YEARS \_\_\_\_\_

**LIST ANY PHYSICIAN 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

SUGARBUSTERS \_\_\_\_\_ LBS

SOUTHBEACH \_\_\_\_\_ LBS

JENNY CRAIG \_\_\_\_\_ LBS

WEIGHT WATCHERS \_\_\_\_\_ LBS

NUTRI-SYSTEM \_\_\_\_\_ LBS

APSEN CLINIC \_\_\_\_\_ LBS

METABOLIFE \_\_\_\_\_ LBS

TOPS \_\_\_\_\_ LBS

PHEN FEN \_\_\_\_\_ LBS

REDUX \_\_\_\_\_ LBS

MERIDIA \_\_\_\_\_ LBS

XENICAL \_\_\_\_\_ LBS

OTHER \_\_\_\_\_

OTHER \_\_\_\_\_

LIST ANY OTHER PROGRAMS YOU HAVE TRIED:

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**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:**

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<b>FAMILY HISTORY</b>	<b>MOTHER</b>	<b>FATHER</b>	<b>SIBLINGS</b>	<b>CHILDREN</b>
HEART DISEASE	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____	_____
STROKE	_____	_____	_____	_____
CANCER	_____	_____	_____	_____
BLOOD CLOTS	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____
BLEEDING PROBLEMS	_____	_____	_____	_____
KIDNEY DISEASE	_____	_____	_____	_____
THYROID DISEASE	_____	_____	_____	_____
OBESITY	_____	_____	_____	_____

**SOCIAL HISTORY**

OCCUPATION \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

LEVEL OF EDUCATION: HIGH SCHOOL / COLLEGE / GRADUATE SCHOOL

DO YOU DRINK ALCOHOL? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

**PLEASE SIGN AND DATE.** (This questionnaire will be part of your medical record)

\_\_\_\_\_

PATIENT'S SIGNATURE

\_\_\_\_\_

DATE

**Authorization to Release Medical Information:**

I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted as valid as original.

Signature \_\_\_\_\_ Date \_\_\_\_\_