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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

Primary Insurance

Insurance Company _____
Member # _____
Relationship to Patient: Self/Mate/Spouse/Child/Other
Subscribers Name: _____
D.O.B _____
Customer Service Contact # _____

Secondary Insurance

Insurance Company _____
Member # _____
Relationship to Patient: Self/Mate/Spouse/Child/Other
Subscribers Name: _____
D.O.B _____
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	_____	_____
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.

By initialing the space below, I specifically authorize Surgical Clinical of Louisiana to use and/or disclosure of the following health information:

_____ Appearance/interview by media on camera, still photos or video footage for use in publications (Print or electronic), websites, audio, video, television, commercial, advertising or film.

_____ _____

Signature Date

1111 Medical Center Boulevard Suite 860 South Marrero, Louisiana 70072 Phone 504-349-6860 Fax 504-349-6865