

# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

## PATIENT QUESTIONNAIRE FORM

### PLEASE COMPLETE –ALL SECTIONS OF PAPERWORK

- **SECTION ONE:** Patient information ... please verify that all info is correct and filled out in its entirety, i.e. work numbers, insurances, address, and phone numbers, etc.
- **SECTION TWO: COMPLETE AND DETAILED Diet history-** includes all over the counter diets as well as medically supervised diets.
- **SECTION THREE:** Make sure to list medications, surgeries, co-morbidities.
- **SECTION FOUR:** Previous doctors with names, address, and phone numbers.

**\*\*\*Please enclose an enlarged copy of the front and back of your insurance card. If you have a secondary insurance please submit front and back copies of that card as well.**

1. Once we receive your packet in our office our administrative assistant will call you to notify you of the receipt of your packet.
2. Your packet will then be forwarded to our insurance coordinator who will call to verify benefits with your insurance company and once that is obtained you will be contacted to schedule a consultation appointment
3. We will start your preauthorization letter once you come in for your consultation and decide to proceed with our bariatric program. At that time a **non refundable \$100.00** fee will be assessed and will be due at that time. The predetermination letter cannot be submitted to your insurance until we have received the **\$100.00 non refundable fee.**
4. Once authorization has been received from the insurance company you will then be called to schedule a surgery date.
5. If you are paying with cash for your surgery ...complete the paperwork and send or fax to our office. Once we have received your packet and you have been approved as a candidate by one of our physicians, our insurance coordinator will call to schedule your consultation appointment.

# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

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## PATIENT INFORMATION

### SECTION ONE

Patient information

DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

Preferred Doctor: Dr. Williams \_\_\_\_\_

Dr. Khan \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

SS#: \_\_\_\_\_

Race: Caucasian/White African American/Black Hispanic Asian Other: \_\_\_\_\_

Marital Status: S M D W

Spouse Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of INS Company: \_\_\_\_\_

Policy#/IC#: \_\_\_\_\_ Group #: \_\_\_\_\_

Benefits Phone #: \_\_\_\_\_ Precert #: \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of INS Company: \_\_\_\_\_

Policy#/IC#: \_\_\_\_\_ Group #: \_\_\_\_\_

Benefits Phone #: \_\_\_\_\_ Precert #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*The above is true and correct to the best of my belief.*

# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

## SECTION TWO

Obesity Evaluation Form

Name: \_\_\_\_\_

*The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.*

### COMPLETE ALL INFORMATION

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_

IDEAL BODY WEIGHT \_\_\_\_\_

EXCESS \_\_\_\_\_

PROCEDURE \_\_\_\_\_ ROUX \_\_\_\_\_ VBG \_\_\_\_\_ LAP BAND \_\_\_\_\_

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Age when you first remember being overweight \_\_\_\_\_

Age when you first began dieting \_\_\_\_\_

**\*\*\*Note:** *Fill out completely, every column, include all diets including anything over the counter, etc (if not filled out completely, this will delay your pre-determination process).*

Diet Program	Pounds Lost	Year	Duration	MD Supervised
Jenny Craig				
Weight Watchers				
Nutri System				
Opti-Med Fast				
Over Eaters Anon				
Behavior Modification				
Fen-Phen				
Redux				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

## SECTION THREE

### Obesity Evaluation Form

Name: \_\_\_\_\_

*The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.*

### MEDICAL HISTORY

Allergies: \_\_\_\_\_

Previous Surgeries & Date: \_\_\_\_\_

Medication & Dosage: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Do you Smoke? \_\_\_\_\_ How Much? \_\_\_\_\_

Do you have a history of alcoholism or chemical dependency? \_\_\_\_\_

Length of Sobriety? \_\_\_\_\_

Do you have a history of suicide attempts? \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## WEIGHT RELATED ILLNESSES

Check the blank if you have the following illness:

- High Blood Pressure
- Heartburn, hiatal,hernia,acid reflux
- Diabetes
- High Cholesterol or triglycerides
- Choking or coughing at night
- Gallbladder disease
- Cancer
- Polycystic Ovarian Syndrome
- Leakage of urine with coughing or straining
- Back Pain
- Joint Problems in hip, knee, ankle, or foot
- Venous insufficiency or blood clots
- Thyroid Disease
- Heart Disease (Please specify and provide records)
- Depression or psychiatric disorder (Please specify and provide records)
- Liver Disease
- Eating Disorder (Please specify and provide records)
- Sleep Apnea
  - Do you use a CPAP

Other medical illnesses (Please List) or specific information related to heart disease, depression, psychiatric disorder, and /or eating disorder:

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*The above is true and correct to the best of my belief.*

# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

## SECTION FOUR

### Previous Doctors

Please list Previous doctors seen for medical conditions/diet control/etc.

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Dr. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*The above is true and correct to the best of my belief.*