LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, P.C

5755 North Point Pkwy, Ste 223, Alpharetta, GA 30022

Tel: 770-500-3660 Fax: 770-500-3664

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 pre-authorization letter once you come in for your consultation and decide to proceed with our bariatric program. At that time a **non refundable *$100.00*** letter 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 letter fee** ******Medicare patient's are exempt from paying the letter 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, P.C.
5755 North Point Parkway Suite 223
Alpharetta, GA 30022
www.bariatricsmd.com

Phone (770-500-3660) **Fax (770-500-3664)**

PATIENT INFORMATION

SECTION ONE

***Date*: _____** ***Referred By*: _____**

Select one: Dr. Williams _____ Dr. Curtis _____
No preference _____

Patient information

Name: _____DOB:_____Age: _____Sex: M/F
SS#:_____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: _____ Alternate Number: _____
Email: _____
Employer: _____Occupation: _____Work Number:_____
Race: Caucasian/White African American/Black Hispanic Asian Other: _
Marital Status: S M D W Spouse Name: _____

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.

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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 _____

SELECT PROCEDURE **ROUX** **LAPBAND** **GASTRIC SLEEVE** **DUODENAL SWITCH**

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:** _____

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

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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:** _____

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

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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:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____

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

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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.