PROMEDICA

Weight Loss Surgery
Patient Information

First Name:_____ Middle Initial:_____Last:_____

Date of Birth:_____ Age:_____ Social Security #:_____

Gender: M F Race: □ Caucasian □ African American □ Hispanic □ Other

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ E-mail:_____

Pharmacy Name & Phone #:_____

Emergency Contact Name:_____ Phone #:_____

Referring Physician, Address, & Phone #:_____

_____

Primary Care Physician, Address, & Phone & Fax #:_____

_____

Employer, Address & Phone #:_____

_____

What is your current occupation? _____

Marital Status:_____ Spouse's Name: _____

Highest level of education: _____

MEDICAL HISTORY

List all medical conditions and hospitalizations. Please list names, addresses, and phone numbers of all your doctors (including your primary care physician, heart doctor, psychiatrist, therapist, or any other physician(s) you see on a regular basis).

Physician/Medical Condition	Address	Phone Number

PAST SURGICAL HISTORY

List all surgeries you have had, including place and date of surgery and surgeon.

Type of Surgery	Surgeon	Hospital	Date

Patient's 50-75 years old last colon cancer screening Date: _____

Other Hospitalizations:

Reason	Date	Hospital

Pregnancy History

Date	Complications	M/F

Can you become pregnant?	yes	no	tubal ligation or hysterectomy
Menopausal?	yes	no	
Mamogram within last year? (over 40)	yes	no	Date: _____Where_____
Pap smear within last year?	yes	no	Date: _____ Where _____

MEDICATIONS

List all prescription and over-the-counter medications you currently take.

Medications	Dose	Frequency	Reason for Medicine

ALLERGIES

List any allergy/reaction to medication, food, and latex products.

Medication/Food/Latex	Type of Reaction

Do you have any of the following or have you been tested for any of the following?

	Yes	No	Never Tested	Year Diagnosed	Treatment
High Blood Pressure					
High Cholesterol					
Acid Reflux/ Heartburn					
History of Blood Clot					
Heart disease					
Sleep Apnea					C-pap Bi-pap
Osteoarthritis/ rheumatoid arthritis					
Back Pain					
Hip Pain					
Knee Pain					
Diabetes **(insulin)**					
Diabetes **(non-insulin)**					
Insulin Resistance					
Gestational Diabetes					
Coronary Artery Disease					
Infertility					
Polycystic Ovarian Syndrome					
Pseudo Tumor Cerebri					
Depression					
Urinary Incontinence					
Asthma					
Lupus					
Crohn's Disease					

SOCIAL HISTORY

	YES	NO	Amount /How Often
Do you consume alcohol?			
Have you ever been treated for alcoholism?			
Do you smoke?			
Do you use oral tobacco products?			
Have you quit smoking recently? (Must be 3 months smoke free before surgery)			When:

How many cups of caffeinated coffee, tea or cola do you drink per day? _____cups

Do you have any difficulty with daily activities, such as tying shoes, walking a flight of stairs, taking a bath?

Activity
1.
2.
3.
4.

FAMILY HISTORY

Is there a family history (grandparents, mother, father, sister, brother, children) or any of the following? If so, please list the relationship.

- ❑ Heart Disease, Stroke _____
- ❑ Diabetes _____
- ❑ Cancer (type) _____
- ❑ High Blood Pressure _____
- ❑ Bleeding Disorder _____
- ❑ Asthma, Hay Fever _____
- ❑ Chemical Dependency _____
- ❑ Depression _____
- ❑ Arthritis, Gout _____
- ❑ Kidney Disease _____
- ❑ Tuberculosis _____
- ❑ Other _____

Age of Mother:_____

Age of Father:_____

NOTE: If deceased list the age at time of death and cause of death.

DIET HISTORY

(Please check all diets you have tried in the past.)

	Month/Year	**Weeks in Program**	**Pounds Lost**	**Pounds Regained**
Medifast-Optifast-HMR				
Overeaters Anonymous				
Weight Watchers				
Nutri-Systems				
Jenny Craig				
South Beach				
Atkins Diet				
Slim Fast				
Other				

Have you tried any physician-supervised diets using prescription weight loss medications?

	Month/Year	**Weeks in Program**	**Pounds Lost**	**Pounds Regained**
Dietician				
Redux				
Phen-Fen				
Meridia				
Xenical				
Adipex-Fastin				
Other				

Review of Systems (Check all that apply to <u>your</u> health)

General
___Fatigue or weakness
___Poor appetite
___Fever
___Chills
___Weight Loss
___Night sweats
Eyes
___Visual changes
___Double vision
Ears, Nose, Throat
___Hearing loss
___Ringing in ears
___Nose bleeds
___Hoarseness
___Sinus problems
___Persistent cough
___Hay fever
___Bleeding gums
Respiratory
___Shortness of breath
___Chronic bronchitis
___Asthma/wheezing
___Coughing blood
___Daily sputum
___Morning cough
___Sleep Apnea
Blood and Glands
___Anemia
___Easy bleeding/bruising
___Swollen glands

Cardiovascular
___Heart attack/MI
___Angina
___Chest pain
___Phlebitis/DVT
___Irregular heart beat
___Difficulty breathing
at night
___High blood pressure
Gastrointestinal
___Abdominal pain
___Nausea
___Vomiting
___Persistent diarrhea
___Constipation
___Blood in stools
___Black stools
___Black stools
___Jaundice
___Heartburn
___Difficulty swallowing
___Painful swallowing
___Change in bowel habits
Genitourinary
___Difficulty urinating
___Blood in urine
___Excessive menstrual bleeding
___Frequent urination
___Incontinence
___Lump in testicles

Musculoskeletal
___Joint pain
___Joint swelling
___Difficulty walking
___Muscle pain
___Back pain
Neurologic
___Dizziness
___Seizure
___Stroke
___Balance problems
___Memory loss
Skin
___Rashes
___Non-healing wound
Breast
___Nipple discharge
___Nipple change
___Breast lump
Emotional
___Depression
___Anxiety
Endocrine
___Thyroid problems
___Hot/cold intolerance
___Excessive thirst
___Excessive hunger

Educational Learning Preferences

What is your preferred method of learning health information? (Circle all that apply)

Written Hands-on/demonstration Visual Auditory/ Verbal No Preference

What is your preferred language for learning health information? (Circle all that apply)

English Spanish Other _____

Patient Insurance Coverage Verification Form

This form is to assist in the review of your health insurance policy coverage and help you determine if your policy contains the benefit of Weight Loss Surgery. Completion of this form will not guarantee your approval for Weight Loss Surgery. A surgical pre-approval can only be obtained after the necessary documentation is sent to your health insurance provider. Also, completing this form does not guarantee the payment for any medical services rendered. Should your health insurance provider deny payment for any services, you will be responsible for the charges. Please note that we cannot be held liable for any incorrect information provided to you by your health insurance provider.

Instructions to complete this form:

1. **Complete the following with the information from your health insurance card:**

Patient Name: _____ Patient Date of Birth: _____

Insurance Name: _____ Address: _____

ID #: _____ _____

Group #: _____ Phone #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____ Insurance Effective Date: _____

2. **Call the toll-free Customer Service number listed on the back of your insurance card. Tell the representative that you would like to check your Policy Benefits. Ask the questions as written, word-for-word, to gather your necessary coverage information. Please do not leave any fields blank.**

Today's Date: _____ To whom am I speaking with? _____

1. Do I have benefit coverage for Weight Loss Surgery for Morbid Obesity, if medically necessary?_____
   CPT codes: (procedure codes) Gastric Bypass 43644, Gastric Sleeve 43775
   Diagnosis Code: Morbid Obesity 278.01

2. Would you please read me the benefit or exclusion? **Write this down word-for-word below:**

_____

_____

_____

_____

_____

_____

3. Is there an insurance lifetime maximum for bariatric surgery? _____

4. Is a referral required to see the bariatric physician? _____

5. Do I need a 5 year Weight History? _____

6. Does my Weight Loss Surgery benefit require a Medically Supervised Weight Loss Program? _____
- Duration of Medically Supervised Weight Loss Program: _____
- Can Weight Loss Program be completed by a dietitian? _____
- Does Weight Loss Program require primary care physician to overlook? _____

7, Is there a fax number that the bariatric physician can fax a pre-determination for my bariatric procedure? _____
- Attention:_____

To check benefits for Medical Nutritional Therapy- for 6 months of supervised medical weight loss:

Call the toll-free Customer Service number listed on the back of your insurance card. Tell the representative that you would like to check your coverage for Medical Nutritional Therapy, CPT code 97802.
Primary diagnosis: Morbid obesity 278.01, diabetes 250.0, hypertension 401.00, hyperlipidemia 272.4.

If there is coverage, we will bill your insurance company directly. If there is no coverage, we will bill you as a cash pay patient at a special rate.

PROMEDICA

Medical Nutrition Therapy
Registered Dietitian Consultation

5700 Monroe St., Suite 101 | Sylvania, Ohio 43560 | Phone: 419-291-6777| Fax: 419-480-6607

Patient Name: _____ Date of Birth: _____

Home phone: _____ Other Phone: _____

Insurance Information: _____

Service Requested:

☐ **Individual Medical Nutritional Therapy (MNT):** One on one nutrition counseling and behavior change therapy provided by a registered dietitian. Follow up will be scheduled as needed.

Diagnosis: Check all that apply
Note: Unable to provide service without diagnosis

	ICD-10	**Endocrine**		ICD-10	**Cardiovascular**
		Type 1 diabetes, uncontrolled			Essential hypertension, unspecified
		Type 2 diabetes, uncontrolled			Hypercholesterolemia
		Diabetes mellitus, type II or unspecified			Hyperlipidemia
		Metabolic syndrome			Sleep Apnea
		Weight Nutrition			**Other**
		Morbid obesity			

Physician Signature: _____ Date/Time: _____

Print Physician Name: _____

Office Phone: _____ Fax: _____