BAPTIST HEALTH®
MEDICAL GROUP

Dear Patient,

Thank you for your interest in our program. We would like you to log in to our patient portal. Our patient portal can help keep you on track throughout your process in preparing for surgery and will allow you to access the **REQUIRED** online seminar.

Link for website: https://bhmgbariatricsportal.pattrax.com/Login

- Add your email address: (Example) **stu@pattrax.com**
- Add your password and fill out additional information

Once you have registered please take the online seminar, this is required before your first appointment.

We look forward to seeing you. Please contact our office with any questions or concerns.

BAPTIST HEALTH®
MEDICAL GROUP

Baptist Health Medical Group-Bariatrics

Patient Information Packet

Baptist Health Weight Loss-Paducah
2601 Kentucky Ave Suite #102
Paducah, KY 42003
270-575-8462
www.baptisthealthweightloss.com

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO
If not, what is your primary language?_____
Please list any other barriers to communication, or special accommodations that you require: _____

Patient Information
First Name:_____ Middle Name:_____ Last Name:_____
Social Security Number: XXX-XX-_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male
Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow
Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____
Religious affiliation:_____ Are you a veteran? ❍ Yes ❍ No

Address Information:
Street Address:_____
City:_____ State:_____ Zip Code:_____
E-mail:_____ Phone (home):_____
Phone (work):_____ Phone (cell):_____

Patient Employment Information:
Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence
Patient's Current Employer:_____ Years Employed:_____
Patient's Employer's address:_____
Patient's Present or Former Occupation:_____
Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_____ Cause:_____
Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?
❍ YES ❍ NO If yes, who?_____Relationship to you?_____

Spouse Information
Spouse's Name:_____ Spouse's Date of Birth:_____
Spouse's Employment Status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence
Spouses's Occupation:_____ Spouse's SSN:_____
Spouse's Employer:_____ Years Employed:_____
Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information – (You must bring a copy of your insurance card with you to your first appointment)

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

Primary Physician

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Facebook ☐Other:_____

Weight Loss History

How long have you been overweight?_____ How long have you been 100 pounds or more overweight?_____

When did you start dieting?_____Age What is the most weight you have ever lost on a single diet?_____lbs.

How did you lose the weight?_____ How long did you sustain the weight loss?_____

Check all that apply:

Can you walk unassisted? ❍ Yes ❍ No Can you walk indoors around the house without stopping?❍ Yes ❍ No

Can you walk at a BRISK pace for 5 minutes without stopping? ❍ Yes ❍ No

Can you do light housework (dusting, dishes) without stopping? ❍ Yes ❍ No

What is the most demanding physical activity you participate in?_____

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?_____

(Month/year)

What limits your activity (joint/back pain, chest pain, shortness of breath, balance, vision

Exercise: ❍ NONE ❍ Walking or Running ❍ Stationary cycle or treadmill ❍ Swimming

❍ Weight Training ❍ Team Sports ❍ Other:_____

Unsupervised Diet Attempts: ❍ **NONE**

❍ High Protein ❍ Low Fat ❍ Mayo Clinic ❍ Fasting ❍ Herbal Life ❍ Calorie Counting

❍ Richard Simmons ❍ Atkin's Diet ❍ Slim Fast ❍ Noom ❍ Living the Life ❍ Cabbage Soup Diet

❍ South Beach ❍ Low Carbohydrate/KETO

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System ❍ Overeaters Anonymous ❍ Weight Watchers ❍ Jenny Craig ❍ HMR

❍ TOPS ❍ Optifast ❍ DASH ❍ LA Weight Loss ❍ Diet Center

❍ Other:_____

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim ❍ Dexatrim ❍ Wellbutrin ❍ Xenical ❍ Diuretics ❍ Phentermine

❍ Other:_____

Behavioral Treatments for Weight Loss: ❍ **NONE** ❍ Hypnosis ❍ Psychological Therapy

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting ❍ Excessive Exercise

❍ Excessive Calorie Restriction/Fasting If so, when and how long was this period of behavior?_____

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness ❍ Makes me happy

❍ Bored ❍ Over Consumption ❍ Inactivity ❍ Emotional Well being

Allergies ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

_____

Foods (List foods and the reaction):_____

Family Medical History: (Check all that apply)

Disease	Alive Deceased	Asthma/ COPD	Cancer Type & Age	Diabetes	Hyper-lipidemia	Hyper-tension	Heart Disease/ Attack	Sleep Apnea	Stroke	Obesity
Mother										
Father										
Siblings (specify brother or sister)										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Social History

Do you smoke/vape now?_____ If yes, how many packs per day?_____ For how long?_____
Have you smoked in the past? _____ If you have quit, how many years since/year you quit?_____
Do you use snuff or chew? _____ If yes, how frequently do you use?_____
Do you consume alcohol now? _____ If yes, how many times per week?_____ Number of drinks each time?_
Do you use street drugs now? _____ If yes, what drugs?_____
How frequently do you use these drugs? _____

Medical History/Review of Symptoms: (Check all that apply)

Medical Problems (check all that apply) ☐ **NONE**

☐ ADD / ADHD ☐ Goiter ☐ Lupus ☐ Anemia ☐ GI Ulcers
☐ Lymphoma ☐ Multiple Sclerosis ☐ Gout ☐ Pancreatic Disease ☐ Liver Disease
☐ Heartburn (acid reflux)/GERD ☐ Hemorrhoids ☐ Sciatica ☐ Kidney Disease
☐ Cirrhosis/Pancreatitis ☐ High Cholesterol ☐ Pseudo tumor Cerebri ☐ Leukemia ☐ Gastric Varices
☐ H/o Cancer / tumors (specify type):_____ ☐ Thrombocytopenia (low platelets)
☐ Pulmonary Embolus ☐ Rheumatoid Arthritis ☐ Chronic Fatigue ☐ HIV / Aids ☐ Jaundice
☐ Deep Vein Thrombosis/DVT ☐ Sleep Apnea – onCPAP/BiPAP?___ ☐ Stomach Ulcers
☐ Diabetes ☐ Enlarged Liver ☐ Fibromyalgia ☐ Kidney Stones
☐ Kidney Failure/Renal Insufficiency ☐ Thyroid Gland Issues(what kind): _____
☐ Hernia (what kind): _____ ☐ Mesh

Surgical Procedure(s): ☐ **NONE** **Date/Year** **Doctor**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____
List any complications of WLS: _____
Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____ ❍ Estimated ❍ Actual

General: ☐ **NONE**

☐ Fevers ☐ Weight Gain ☐ Tired / No Energy ☐ Appetite Change ☐ Night Sweats

☐ Insomnia ☐ Hair Loss ☐ Other:_____

Psychiatric ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Alcoholism/Substance Abuse ☐ Anxiety ☐ Depression ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Bipolar Disorder ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Other:_____

HENT (OPHTHALMIC/ENT) ☐ **NONE**

☐ Wear contact /glasses ☐ Vision Problems ☐ Hearing Problems ☐ Sinus Drainage ☐ Nose Bleeds

☐ Hoarseness ☐ Dentures, Partial/Full ☐ Allergies ☐ Regular Ear Infections ☐ Other:_____

Hematological & Lymphatic (Blood/Lymphatic) ☐ **NONE**

☐ Bruise Easily ☐ Swollen Lymph Nodes ☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use

☐ Prior blood Transfusion ☐ Other:_____

Endocrine ☐ **NONE**

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Cold Intolerance

☐ Warm/Heat Intolerance ☐ Fatigue ☐ Pre-Diabetes ☐ Other:_____

Respiratory ☐ **NONE**

☐ Chronic Cough ☐ Shortness of Breath at Rest ☐ Wheezing ☐ Coughing up blood ☐ Use of Oxygen

☐ Snoring ☐ Asthma ☐ COPD/Emphysema ☐ Other:_____

Cardiovascular ☐ **NONE**

☐ Chest Pain w/ Activity ☐ Rhythm Changes ☐ High Blood Pressure ☐ Palpitations

☐ Varicose Veins ☐ Dyspnea on Exertion ☐ Ankle Swelling ☐ Ankle / Leg Ulcers

☐ Elevated Triglycerides ☐ Phlebitis / Adenal swelling ☐ Clogged Heart Arteries ☐ Rapid Heart Beat

☐ Irregular Heart Beat ☐ Atrial Fibrillation ☐ Elevated Cholesterol ☐ Heart Murmur

☐ Cramping in legs when walking ☐ Rheumatic Fever / Valve Damage / MVP ☐ Stroke

☐ Other:_____ ☐ Heart Attack ☐ Congestive Heart Failure

Gastrointestinal ☐ **NONE**

☐ Diarrhea ☐ Blood in Stool ☐ Constipation ☐ Abdominal Pain ☐ Difficulty Swallowing

☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Nausea / Vomiting ☐ Other:_____

☐ IBS ☐ Barrett's Esophagus

Kidney/Bladder ☐ **NONE**

☐ Blood in Urine ☐ Leaking urine w/ cough/laugh/sneezing ☐ Trouble starting urine ☐ Burning/Pain on urination

☐ Urinary Urgency/Frequency ☐ Overall Loss of Bladder Control ☐ Other:_____

Gynecologic/Breast ☐ **NONE**

How many pregnancies have you had:_____ ☐ Problems Conceiving/Infertility ☐ Currently Pregnant ☐ Menstrual Irregularity

☐ Menstrual Pain ☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Breast Nipple Discharge

☐ Breast Lumps ☐ Polycystic Ovaries (PCOS) ☐ Breast Pain ☐ Other:_____

Musculoskeletal ☐ **NONE**

☐ Back Pain ☐ Broken Bones ☐ Muscle Pain / Spasm ☐ Joint Pain: (which) _____

☐ Other:_____

Neurologic ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Seizures or convulsions ☐ Weakness ☐ Numbness / Tingling

☐ Migraines ☐ Other:_____

Dermatological (Skin) ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Raised Scars) ☐ Poor Wound Healing ☐ Rashes under Breasts/Skin Folds

☐ Hair or Nail Changes ☐ History of boils ☐ Other:_____

Pharmacy Information

Name:_____ Phone Number:_____

List Prescribed Medications:	Taken for what condition:	Dosage/How Often:
☐ **NONE**		

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	Taken for what purpose:	Dosage/How Often:

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before bringing in your packet:

- ☐ Filled out this form as completely as possible
- ☐ Made a copy of the front and back of your insurance card
- ☐ Called your insurance and completely fill out the

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare or Medicaid but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

Instructions:

1. Call the member services number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
4. Once complete, return this form, along with a copy of your insurance card(s), to our office.
5. Please also make sure that you submit your patient profile packet via mail or internet.
6. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
    a. **Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. You must complete this form if you have a Medicare supplement plan, Medicare Replacement plan, or a Medicare HMO.**

Fill in this information before you call the insurance company. Please write clearly.	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	

#	Question for Representative	Answer from Representative
1	Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	☐ **Yes** (Continue with this form.) ☐ **No** (Complete #s 2, 9 & 10 then end the call.) **See explanation below
****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	

3	Do I have a Bariatric Lifetime Maximum?	
4	Am I required to have Weight Loss Surgery at a Center of Excellence facility or Blue Distinction Center?	
5	Is Baptist Health Medical Group-Bariatric (Dr. Anthony Davis) in my network? Tax ID#: 205497203	
6	Is the facility in my network? Baptist Health Tax ID# 610444707	
7	What is the effective date of my policy?	
8	Is a referral required for specialist office visits?	
9	What are the preoperative requirements for surgery approval?	
10	Is nutrition counseling for obesity covered? What %?	
11	Which procedures are covered? At what %? Sleeve Gastrectomy (43775)? Gastric Bypass (43664)? Adjustable Gastric Banding (43770)?	
12	What is the deductible per calendar year?	
13	What is the maximum out of pocket per calendar year?	
14	Is the deductible applied to the maximum out of pocket?	
15	Name of the representative	
16	Date you spoke to representative	
17	Reference number for call	

Disclaimer:

- Baptist Health Medical Group- Bariatric is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by Baptist Health Medical Group- Bariatric.

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**

300047

MGW BAR SURG PAD

BH VERBAL RELEASE AUTHORIZATION [Authorization to Verbally Disclose Protected Health Information with Family Member(s) or Other Designated Person(s)]

I _____ hereby authorize MGW BAR SURG PAD
(Patient's Name – *please print*) (Provider's Practice/Department Name - *please print*)

to verbally share the following information:

- ❑ Appointments
- ❑ Payments/Billing
- ❑ Diagnostic procedure results
- ❑ Prescription refills
- ❑ Culture results
- ❑ Lab results
- ❑ Plan of Care/Progress

with the individuals listed below who may be involved with my health care or payment for my health care:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

❑ I authorize my provider or other staff in his/her practice/department to leave detailed messages regarding the above medical information on my answering machine/voicemail at:

- ❑ Home ❑ Cell/mobile
- ❑ All phone numbers listed

❑ I prefer that my provider or other staff in his/her practice/department speak with me personally regarding my medical information. Do not leave messages concerning my medical information.

I understand that I have the right to revoke this authorization at any time by written notification to MGW BAR SURG PAD; however, the revocation will not apply to information that already has been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to advise MGW BAR SURG PAD of changes to my telephone numbers or my preferences regarding telephone messages. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations. The provider expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

_____ _____
Patient's Signature (parent/guardian if patient is a minor) Date