Dear Valued Patient,

My name is Samantha Sanders and I am the Practice Manager with Baptist Health Medical Group Floyd Bariatrics. On behalf of the entire team, I would like to welcome you and thank you for your interest in our program. BHMG Floyd Bariatrics started in 2016 and has been a growing program every year since. It is because of patients like you that we continue to grow and are committed to providing you the best care possible. If there is anything you need throughout your journey, please reach out to me directly at, 812-949-7151.

Congratulations! You have completed the first step in your weight loss journey by receiving this packet. Once you have returned your completed packet our Bariatric Team will guide you throughout the surgical process and work diligently to help you succeed before and after surgery.

We look forward to serving you in your quest for better health. Thank you again for choosing Baptist Health Medical Group Floyd Bariatrics.

Sincerely,

Samantha Sanders
Practice Manager

Baptist Health Medical Group Floyd Bariatrics
2125 State Street, Suite 1
New Albany, IN 47150

812.949.7151 office
812.989.7191 fax
BHMGBariatrics@bhsi.com

1. Attend zoom seminar or watch pre-recorded seminar

2. Return completed new patient paperwork, copy of insurance card(s) (front & back), copy of prescription card (if applicable), and photo ID for benefits verification and clinical review
    - You may return your packet via mail, email, fax or in person

3. Our office will call to discuss insurance benefits and schedule appointments
    - **This can take up to 30 days**

4. Initial intake appointment will include:
    - Nutrition Education Group Class
    - Exam and medical education with APRN
    - Psychiatric exam
    - Nutrition Evaluation with Registered Dietitian
    - Meeting with surgery coordinator to discuss insurance requirements and surgical clearances

**This is an extremely important appointment that we ask you be committed to having surgery before you schedule.

5. Submit necessary documentation to the office
    - Insurance required document (i.e., Supervised Weight Loss Visits, Food and Exercise logs, medical testing and clearances)

6. Our office will submit your file to insurance for prior-authorization.
   Prior authorization is not a guarantee of payment. Medical necessity of the services will be determined by insurance before they are provided.
    - **It can take up to 60 days to have surgery once you have completed everything.**

7. Pre-Op Appointment will include:
    - Pre-op group education class with Registered Dietitian
    - Surgical consent, education, and meeting with Dr. Gore

If you choose to purchase protein shakes in our office for the Liver Reduction Diet it is approx. $45.00-$95.00 (Not covered by insurance)

8. Receive a Surgery Date
   All surgery dates are subject to change

- We offer a Bariatric Support Group via Zoom the 2nd Thursday of the Month with our Registered Dietitian.

Return completed paperwork to:

Email: BHMGBariatrics@bhsi.com

Address: 2125 State St, Suite 1
New Albany, IN 47150

Fax: 812-949-7191

We appreciate your business and take pride in helping our patients succeed. Please be advised that our office has a no show and cancellation policy. If you fail to make your scheduled appointments, you may be dismissed from the bariatric program.

Determining Your Insurance Benefits

This form does not need to be completed for Medicare, Medicaid, Medicaid MCO's but it does need to be filled out for Medicare Replacement, Medicare HMO, and Medicare Supplements.

This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery, and to give you an idea of your out of pocket cost for surgery. Please follow the instructions below

Instructions:

1. 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.
2. Call the customer service number located on your insurance card and speak to a customer service representative.
3. Tell the representative that you would like to check policy benefits.
4. 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.
5. **Do not leave any fields blank.**
6. **Once complete, sign the back of the form. Failure to do so will result in the form being returned.**
7. Return this form, along with a copy of your insurance card(s), photo ID, and patient profile packet to our office.

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	

#	Questions for the Representative	Answer from the 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** (Skip #2, #3, and continue with this form.) **NO** (Complete #s 2, 3, 28, 29, 30 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.	What are the exclusions for surgical treatment of obesity?	
4.	Which procedures are covered?	

	Laparoscopic Sleeve Gastrectomy (43775)? Laparoscopic Gastric Bypass (43644)?	
5.	Do I have a Bariatric Lifetime Maximum?	
6.	Am I required to have weight loss surgery at an accredited facility or specific hospital system?	
7.	If yes, what accreditation or hospital system?	
8.	Is Baptist Health Medical Group-Bariatrics (Dr. Lanny Gore) in my network? Tax ID# 205497203	
9.	Is the facility in my network? Baptist Health Tax ID# 610444707	
10.	What is the effective date of my policy?	
11.	What is the calendar year renewal date?	
12.	Is a referral required?	
13.	Do I have a pre-existing clause?	
14.	If yes, what is the end date of the pre-existing clause?	
15.	What is the deductible per calendar year?	
16.	How much have I met towards my deductible?	
17.	What is the maximum out of pocket per calendar year?	
18.	How much have I met towards my maximum out of pocket?	
19.	Is the deductible applied to the maximum out of pocket?	
20.	What is the co-insurance percent for my policy?	
21.	What are my financial obligations to the doctor for inpatient surgery?	
22.	What are my financial obligations to the doctor for outpatient surgery?	
23.	What are my financial obligations to the hospital for inpatient surgery?	
24.	What are my financial obligations to the hospital for outpatient surgery?	
25.	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
26.	What is my copay for a specialists office visit?	
27.	What is the fax number for pre-determination?	
28.	Name of the representative	
29.	Date you spoke to representative	
30.	**If you have an exclusion in your policy, would you like to self-pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.**	○ **Yes** ○ **No**

Disclaimer:

By signing below, I certify the following

- I have read and understand the instructions that were provided to me.
- I have read and understand the disclaimer which includes that I am not approved for surgery
- I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.

Patient Signature: **Date:**

- Baptist Health Medical Group Floyd Bariatrics 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 Floyd Bariatrics.

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Patient Information Packet

Preferred Procedure:

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ Laparoscopic Sleeve Gastrectomy

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:

_____

Do you have a healthcare companion or caretaker? ❍ YES ❍ NO

Patient Information

First Name:_____ Middle Name:_____ Last Name:
_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered
❍ Widow How many children do you have (please list ages)?_____

_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____Patient's level of Education:
_____

What is your height?_____ft _____in How much do you weigh?_____lbs. BMI:
_____

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:_____ Can you walk unassisted? ❍

Yes ❍ No How far before needing rest?_____ (Approximate # of feet) 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)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?_____ Relationship to you?_____

Do you have a living will? ❍ YES ❍ NO

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**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Baptist Health Medical Group to discuss my process, diagnostic test results and any scheduled

appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician

First Name:_____ Last Name:_____

Street Address:_____

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

Have you discussed Weight Loss Surgery with your physician? ❍ Yes ❍ No is your physician supportive? ❍ Yes ❍ No

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

Blood Consent

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Weight Loss History

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, please provide this information when entering in your previous surgical history.)

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?_____ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ NONE

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____

Supervised Diet Attempts: ❍ NONE

❍ Nutri-System	❍ Overeaters Anonymous	❍ Weight Watchers	❍ Jenny Craig
❍ TOPS	❍ Optifast	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_____	

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

❍ Acutrim	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol
❍ Redux	❍ Byetta	❍ Plegine	❍ Sanorex	❍ Meridia
❍ Xenical	❍ Diuretics	❍ Pondimin	❍ Phenteramine	
❍ Fen-Phen,				

# of months:_____ ❍ Other:_____

Behavioral Treatments for Weight Loss: ❍ NONE

❍ Hospitalization	❍ Hypnosis
❍ Physical Therapy	❍ Psychological Therapy
❍ Residential Programs	❍ Other:_____

Exercise: ❍ NONE

❍ Walking or Running	❍ Stationary cycle or treadmill
❍ Swimming	❍ Weight Training
❍ Team Sports	❍ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

- If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

- If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

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

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

Please tell us how your weight is interfering with your health and life? _____

_____

Why are you seeking weight loss surgery? _____

_____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

_____

_____

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

General: ☐ **NONE**

☐ Fevers ☐ Weight Gain ☐ Tired / No Energy
☐ Night Sweats ☐ Insomnia ☐ Hair Loss
☐ Appetite Change ☐ Other:_____

Head and Neck ☐ **NONE**

☐ Wear contacts / glasses ☐ Vision Problems ☐ Hearing Problems
☐ Sinus Drainage ☐ Nose Bleeds ☐ Hoarseness
☐ Dentures, Partial / Full ☐ Allergies ☐ Glaucoma
☐ Regular Ear Infections ☐ Blurred / Double Vision ☐ Other:_____

Cardiovascular ☐ **NONE**

☐ Heart Attack ☐ Chest Pain w/ Activity ☐ Rhythm Changes
☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Palpitations
☐ Varicose Veins ☐ Shortness of Breath on Exertion ☐ Ankle Swelling
☐ Ankle / Leg Ulcers ☐ Elevated Triglycerides ☐ Phlebitis / DVT
☐ Clogged Heart Arteries ☐ Rheumatic Fever / Valve Damage / MVP ☐ Rapid Heart Beat
☐ Irregular Heart Beat ☐ Cramping in legs when walking ☐ Heart Murmur
☐ Atrial Fibrillation ☐ Elevated Cholesterol ☐ Other:_____

Respiratory ☐ **NONE**

☐ Asthma ☐ Emphysema / COPD ☐ Bronchitis
☐ Pneumonia ☐ Chronic Cough ☐ Shortness of Breath at Rest
☐ Use of CPAP / BiPAP ☐ Use of Oxygen ☐ Snoring
☐ Pulmonary Embolism ☐ Sleep Apnea ☐ Had a sleep study; when:_____
☐ Other:_____

Gastrointestinal ☐ **NONE**

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers
☐ Diarrhea ☐ Blood in Stool ☐ History of elevated Liver Enzymes
☐ Constipation ☐ IBS (irritable bowel syndrome) ☐ Umbilical Hernia
☐ Difficulty Swallowing ☐ Hemorrhoids ☐ Fissure / Polyps
☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia
☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease
☐ Nausea / Vomiting ☐ GERD ☐ Incisional Hernia
☐ Barrett's Esophagus ☐ Other:_____

Bladder/Kidney ☐ **NONE**

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

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

Gynecologic (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer
☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain
☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post-Menopausal

Current method of birth control: _____

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____
☐ Pain ☐ Cancer Date of last Mammogram: _____

Musculoskeletal ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain
☐ Hip Pain ☐ Wrist Pain ☐ Back Pain
☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain
☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain
☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus
☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis
☐ Fibromyalgia ☐ Other:_____

Neurologic ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome
☐ Stroke ☐ Seizures or convulsions ☐ Weakness
☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis
☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

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

☐ Depression/Anxiety ☐ Hospitalized for psychiatric problems When:_____
☐ Bipolar Disorder ("manic-depression") ☐ Attempted suicide When: _____
☐ Alcoholism / Substance Abuse ___ Past? ___ Present? ☐ Experience Suicidal Ideation When: _____
☐ Been in a chemical dependency program When: _____ ☐ Inflicted self-harm When: _____
☐ Schizoaffective disorder ☐ Victim of Mental/Emotional/Sexual/Physical Abuse
☐ Borderline Personality Disorder ☐ Other:_____

Endocrine ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter
☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor
☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)
☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout
☐ PCOS

☐ Other:_____

Blood/Lymphatic ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS
☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes
☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE
☐ Prior blood Transfusion ☐ Other:_____

Skin ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing
☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea
☐ Hair or Nail Changes ☐ Other:_____

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

Current Pharmacy:	**Address:**	**Phone #**

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:**

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):_____

Surgical Procedure(s):	☐ NONE	Year		Year
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____

Hernia: ❍ Hiatal ❍ Inguinal ❍ Incisional ❍ Umbilical

Tubal Ligation	_____	Knee:	❍ Right ❍ Left	_____
Cesarean Section	_____	Breast Biopsy:	❍ Right ❍ Left	_____
Colonoscopy	_____	Anti-reflux procedure / Nissen Fundoplication		_____
Hemorrhoidectomy	_____	Kidney Surgery		
Colon Resection	_____	Back:_____		_____
Endoscopy/EGD	_____	Other:_____		_____

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

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea	❍ Heart Stopped	❍ Woke up during procedure
❍ Vomiting	❍ Stopped Breathing	❍ Other:_____
❍ Difficulty Waking Up	❍ Difficulty Urinating	

Social History

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years do/did you drink alcohol? _____Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

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Could someone help care for you if you were seriously ill? ❍ Yes ❍ No Who?_____

Are there people for whom you are the primary care giver? ❍ Yes ❍ No Who?_____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Name of person completing packet: _____

Relationship to patient: _____

Signature of person completing packet: _____

Signature of patient: _____

Thank you for taking the time to complete the Patient Information Packet.

Please return this packet, a copy of your insurance cards front and back, and all signed insurance forms to Baptist Health Medical Group.


BAPTIST HEALTH
MEDICAL GROUP


AETNA
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QUALITY
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AMERICAN COLLEGE OF SURGEONS
MBSAQIP
ACCREDITED
CENTER
QUALITY
PROGRAM
AMERICAN SOCIETY FOR METABOLIC AND BARIATRIC SURGERY


Blue
Distinction
Center
Bariatric


OPTUM
Center of Excellence