

**WLS  
NEW PATIENT  
INFORMATION PROFILE**

# MIDTOWN SURGICAL SPECIALISTS

SPECIALISTS IN GENERAL AND VASCULAR SURGERY

Have you ever been a patient in this office for any doctor? Yes\_\_\_\_ No\_\_\_\_

**Patient's Full Name:** \_\_\_\_\_  
(please print) (First) (Middle) (Last) (name called)

**Mailing Address:** \_\_\_\_\_  
(Street / apt #) (City) (State) (Zip)

\_\_\_\_\_  
(Date of Birth) (Age) (Sex) (Marital status)

\_\_\_\_\_  
(Area code) (Phone #) (Cell #) (Work #)

\_\_\_\_\_  
(email address)

\_\_\_\_\_  
( Social Security #) (employer) (employer phone # & ext.)

=====  
\_\_\_\_\_  
(Spouse's name) (Spouse's employer & phone #)

\_\_\_\_\_  
(Spouse's Date of Birth) (Spouse's SS #)

=====  
Please state reason for seeing doctor today: \_\_\_\_\_

**Dr. that referred you here:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ 2<sup>nd</sup> ph # \_\_\_\_\_

Primary Insurance Co: \_\_\_\_\_ Insured: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Insured: \_\_\_\_\_

**Payment Information:** *You will receive statements for balances due which are payable upon receipt. We are happy to assist you with account issues. If your account becomes delinquent & is referred to a 3<sup>rd</sup> party for collections, you are responsible for all collection and/or attorney fees. Per your insurance contract all co-pays are due at the time of office visits. Thank you for giving us the opportunity to serve you. Please refer to our payment policy for further information.*



**FAMILY HISTORY**

Family History:	Family Relationship:
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Aneurysms	

**SOCIAL HISTORY**

Occupation:	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered
Tobacco use:	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently (list packs/day and # of years)
Alcohol:	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily

**REVIEW OF SYSTEMS**

Check the boxes that apply to YOU.

Constitutional:	<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss
Eyes:	<input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision
Cardiovascular:	<input type="checkbox"/> Heart attack or chest pain <input type="checkbox"/> Pain in legs with walking
ENT:	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore throat
Respiratory:	<input type="checkbox"/> Excessive shortness of breath <input type="checkbox"/> Chronic/Persistent cough
Gastrointestinal:	<input type="checkbox"/> Recent blood in stool <input type="checkbox"/> Heart Burn
Genitourinary:	<input type="checkbox"/> Difficulty with urination <input type="checkbox"/> Incontinence
Musculoskeletal:	<input type="checkbox"/> Leg cramps <input type="checkbox"/> Joint pain
Skin/Breast:	<input type="checkbox"/> Breast mass <input type="checkbox"/> Nipple discharge
Neurological:	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder
Endocrine:	<input type="checkbox"/> Hot/Cold episodes <input type="checkbox"/> History of thyroid disease
Hematology/Lymphatic	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> History of blood clots
Allergy/Immunology:	<input type="checkbox"/> Problems with anesthesia <input type="checkbox"/> Latex or tape allergy

Please list any other symptoms you are having in this area:

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The above is true and correct to the best of my knowledge. (Please sign below)

Signature \_\_\_\_\_ Date \_\_\_\_\_

What is the biggest reason you are interested in weight loss surgery: \_\_\_\_\_

What are your weight loss goals: \_\_\_\_\_

What is a good weight for you? \_\_\_\_\_

What does your Family think of you persuing Weight loss surgery? \_\_\_\_\_

- Supportive    Skeptical    unsupportive    Think your crazy

What have you done to research the option of weight loss surgery?

- Internet research  
 Information Session  
 Books  
 Other Patients

What operation are you considering?

- gastric bypass    gastric banding    sleeve gastrectomy    duodenal switch    not sure

## WEIGHT HISTORY

Please indicate your weight at the following times during your life.

Use the empty boxes for other significant life events

Age	weight
preteen	
18	
25	
30	
35	
40	
50	
60	
Pregnancies Age: Age: Age:	
Marriage (age)	

**Notes**

# MEDICAL WEIGHT LOSS HISTORY

For how long have you been seriously trying to lose weight? \_\_\_\_\_ years

Rate your seriousness at dieting attempts: 0-----10

Rate how desperately you want to lose weight 0-----10

Rate how frustrated are you with medical weight loss programs: 0-----10

What are you willing to do to loose and maintain a significant amount of weight loss?:

\_\_\_\_\_

What is the most weight you have ever lost with dieting? \_\_\_\_\_ lbs

What did you do to loose this weight? \_\_\_\_\_

How long did it take to lose this weight? \_\_\_\_\_

How long did it take to regain the weight? \_\_\_\_\_ and how much did you regain? \_\_\_\_\_

## Which of the following have you tried at some time?

### Dieting - fad diets, something you have read about, etc

- Adkins Diet  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
South Beach  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Grapefruit/cabbage Diet  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Other \_\_\_\_\_  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

### Exercise - walking, swimming, sporting activities, etc

- Gym Membership  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Personal Trainer  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Other \_\_\_\_\_  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

### Commercial weight loss programs:

- Jenny Craig  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Weight Watchers  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
PHC  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Nutrisystem  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

Others - please list: \_\_\_\_\_

### Diet Pills:

- Phen/Fhen  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Adipex  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Xenical  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Redux  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
OTC Medication  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Other \_\_\_\_\_  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

### Professional Advice:

- Family Doctor  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Weight Loss Specialist/MD  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Dietitian  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Psychologist  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Other \_\_\_\_\_  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

### Very low calorie diets

- Medifast  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_  
Optifast  when (age/year): \_\_\_\_\_ Wt Lost \_\_\_\_\_

## PHYSICAL EFFECTS OF OBESITY

What is the single biggest reason you are considering weight loss surgery: \_\_\_\_\_

\_\_\_\_\_

Do you suffer any of the following physical limitations because of your weight?

Get short of breath easily	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Always tired and lethargic	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cannot take part in family outdoor activities	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have difficulty buying clothes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have difficulty with personal hygiene	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cannot cut your toenails/tying shoes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Difficulty sitting in chairs with arms	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Travel, especially in planes, is difficult	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

What is the biggest limitation your weight presents in your life:

\_\_\_\_\_

\_\_\_\_\_

List any other particular difficulties that your weight is currently causing in your life: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Diet History

What is your daily schedule:

When do you get up: \_\_\_\_\_

What are your work hours: \_\_\_\_\_

When do you go to bed: \_\_\_\_\_

Other: \_\_\_\_\_

Meals: describe in general a typical day of eating

Meal	Time	Where	What
Breakfast			
snack			
Lunch			
snack			
Dinner			
snack			

Beverages (regular sodas, diet sodas, tea sweet/unsweet, juices, crystal light, etc)

Beverage	How Much	When/What Meal

What type of bad eating behavior do you have?

- Big portions  
  Sweet eater  
  Snacker (grazer)  
  soda drinker  
  skip meals

Rate your portion size?  
 small  
 medium  
 large

**PATIENT ACKNOWLEDGMENT FORM**

Patient's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Midtown Surgical Specialists works very hard to protect patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Midtown Surgical Specialists., P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Midtown Surgical Specialists, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and contains a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

Midtown Surgical Specialists., P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Midtown Surgical Specialists., P.C. will provide me with the most current "Notice of Privacy Practices".

Midtown Surgical Specialists., P.C. has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgments/authorizations; reasonable time frames for requests, charges for copies and non-routine information needs; etc. I will assist Midtown Surgical Specialists., P.C. by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Midtown Surgical Specialists., PC's "Notice of Privacy Practices".

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

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Relationship to patient if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

With this consent, Midtown Surgical Specialists., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and operations such as appointment reminders, insurance items and calls pertaining to my clinical care, including tests results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Midtown Surgical Specialists., P.C. to release my protected health information to my family members both verbally and written, and to mail prescription, disability forms, etc. to me or my family members as needed.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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

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Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc)

Printed name of Patient and/or Personal Representative: \_\_\_\_\_

# MIDTOWN SURGICAL SPECIALISTS

SPECIALISTS IN GENERAL AND VASCULAR SURGERY

## Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of service your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account (deductibles). We appreciate payment in full within 10 days. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through use of:
  - a. Payment with a credit card
  - b. Extension of a line of credit through a medical services credit company
  - c. Establishing a monthly payment contract with our office
3. Statements will be mailed to you monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia.
4. Prior to elective surgery we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We appreciate payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing afterwards.
5. **Questions or concerns regarding your bills should be addressed directly with the billing staff and not your physician.**
6. We take pride in our relationship with you and appreciate you giving us the unique opportunity to care for you and your family. We understand that medical care can be costly. We are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter.

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Patient Signature

Date