GHIATH ALSHKAKI, MD, FRCSI.

**For Office Use Only**

|  |  |
| --- | --- |
| RX | Pre-op To be done within 60 days of surgery date |
|  | Cardiac Clearance |
|  | EKG |
|  | Split Night Polysommography ( sleep study) |
|  | Ultrasound of Gallbladder |
|  | Ultrasound of Pelvis |
|  |  |
|  |  |
|  | EGD |
|  | Colonoscopy For are more that 50 or 45 w/ family history of colon cancer |
|  | Psychiatric Clearance |
|  | Bone Density Scan of Hip/ EXA Scan |
|  |  |
|  |  |
|  |  |
|  | Nutrition consult |
|  |  |
|  |  |
|  | Seminar Attendance |
|  |  |
|  |  |
|  | Letter of Medical Necessity for weight reduction Surgical procedure from PCP (she/he was under supervised weight reduction follow up ) |
|  | Education Material Given to the patient |

**Please coordinate with your PCP to complete all the above tests and   
to fax all the tests reports to us all at once.**

|  |  |
| --- | --- |
|  | Pre-op Blood work to be done within 30 days of surgery date |
|  | CBC, CMP, Lipid Panel, PT, INR, PTT |
|  | Hepatitis B Surface Antigen, Hepatitis C Antibody |
|  | Ceruloplasmin, Iron, Ferritin, Total Iron Binding Capacity |
|  | Pregnancy Test ( female only) Quantitative / PSA Level ( males only) |
|  | Urinalysis |
|  | TSH |
|  | H Pylori Test |

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| RX | Pre-op To be done within 60 days of surgery date |
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|  | Ceruloplasmin, Iron, Ferritin, Total Iron Binding Capacity |
|  | Pregnancy Test ( female only) Quantitative / PSA Level ( males only) |
|  | Urinalysis |
|  | TSH |
|  | H Pylori Test |

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BARIATRIC OUTPATIENT TREATMENT PROCEDURE LOG

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P.C.P.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tests Ordered: Date Completed: Filed in Medical Record:

Cardiac Clearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Sleep Apnea Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Ultrasound of Abdomen/Pelvic\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# EGD/Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Bone Density Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Psychiatric Clearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Letter from PCP\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Blood Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Letter of medical necessity for weight reduction surgical procedure (She/he was under supervised diet)**

Ghiath Alshkaki, MD, FRCSI

6400 Arlington Blvd, Suite 940 Tel: 703-942-8770

Falls Church, VA 22042 Fax: 703-942-8709

## *PATIENT’S CALL LOG*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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**TYPE OF SURGERY TO BE SCHEDULED**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITAL**: ALEXANDRIA FAIRFAX GEORGE WASHINGTON

**DATE OF SURGERY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only**

PATIENT FLOW CHECKLIST

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Seminar

→ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ → Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

→ Quiz \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ → Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□⁭ Bariatric Patient Education Syllabus given to patient

□⁭ Health Questionnaire collected

□⁭ Signed Bariatric Patient Education Seminar Acknowledgement collected

Consultation Appointment

→ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

→ Weight: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_

→ Target weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Excess Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

HR: \_\_\_\_\_\_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

→ Preoperative laboratory testing given to patient

→ Expected surgical method: □ Lap ⁭ □Open

→ Expected surgical procedure: □ D/S □R NY

→ VBG with Sleeve □LAP BAND® ⁭□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance / Financial:

□ Self Pay

□ General insurance information foe the prospective patient signed by patient:

□ Authorization letter/ package sent to insurance → Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Authorization number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hard Copy Authorization received

□ Financial responsibility explained to patient: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Patient payment received

□ Insurance status verified 24 hours prior to surgery

Surgery:

□ Surgery scheduled with OR

→ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Weight, BMI, and special instructions given to OR

□ Lap Versus open instructions given to OR

□ Patient notified of surgery date by telephone

□ Bariatric surgery guide package sent to patient

□ Preoperative appointments checklist sent to patient

□ Bariatric follow-up guide for PCP sent to PCP

Preoperative Appointment:

→ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Preoperative instructions given to patient

□ RX given to patient

□ LGB Blood product release signed by patient

□ Bariatric surgery patient contracts.

**Office Use Only**

Insurance Verification Form

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

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Id #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims and Benefits Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail Pre D Letter to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Patient eligible? □ Yes □ No Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have benefits for Lap Band (CPT 43846) □ Yes □ No

Does the patient have benefits for Lipectomy (CPT 15831) □ Yes □ No

Does the patient have benefits for VBG □ Yes □ No

Does the patient have benefits for Gastric By Pass □ Yes □ No

Does the patient have benefits for Sleeve □ Yes □ No

Phone to Pre- Cert: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pre-Existing Period? □Yes □No Met? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person at insurance company I spoke to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use Only**

Initial Diagnosis Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year old male / female with history of long standing morbid obesity. Developed co-morbidities associated with morbid obesity status.

The patient has attempted to reduce weight by conventional methods for an extended time with failed results and is considering bariatric surgery as the treatment of last resort. The surgical procedure ( ) was explained to the patient in length. Benefits and potential complications were fully discussed ( staple line leak, obstruction, infection, pulmonary embolism, pneumonia, hair loss, gastric or duodenal ulcer, dumping syndrome, vomiting, etc, and death). The success rate of this procedure is 75-80%

(weight loss ranging between 50% to 90%). The patient’s commitment to attend post operative aftercare behavior modification program with a psychologist and a dietitian was emphasized. Life long follow-up and increase in exercise activities were stressed. The success of the operation depends heavily on the understanding of the surgery and the motivational level of the patient.

The patient understood everything and has consented to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient will be cleared for surgery according to protocols.

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **THE FOLLOWING PAGES MUST BE COMPLETED BY THE PATIENT**

**Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| PATIENT NAME: FIRST M.I. LAST | | DATE OF BIRTH | SOCIAL SECURITY # | |  | MALE / FEMALE? M or F |
| HOME ADDRESS APT # | | CITY | STATE | ZIP | HOME PHONE | |
| EMPLOYER ADDRESS | | | | | WORK PHONE | |
| OCCUPATION | | REFERRED BY: FIRST and LAST NAME | | | CELL PHONE | |
| ALLERGIES TO MEDICATIONS | PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known) | | | | MARITAL STATUS \_\_\_\_\_S \_\_\_\_\_M \_\_\_\_\_W \_\_\_\_\_D | |
| SPOUSES NAME | | WORK PHONE: | | OCCUPATION | | |
| PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU) | | | | | TELEPHONE | |
| POLICY HOLDER NAME | SOCIAL SECURITY NUMBER | | DATE OF BIRTH | FINANCIALLY RESPONSIBLE PERSON \_\_\_\_PATIENT \_\_\_\_SPOUSE \_\_\_\_PARENT \_\_OTHER | | |
| EMPLOYER ADDRESS | | | | | WORK PHONE | |

|  |  |
| --- | --- |
| **Primary Insurance Billing Information** | **Secondary Insurance Billing Information** |
| **Ins. Co. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City, State & Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ID.No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Group Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Person's Name)  **Subscribers Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber's Social Security #** | **Ins. Co. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City, State & Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ID.No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Group Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Person's Name)  **Subscribers Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Subscriber's Social Security #** |

**Patient Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature/date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAYMENT POLICY**

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Giath Alshkaki, MD, to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

**The information I provided above in the previous page**

**(Insurance and personal demographic information page) are correct.**

**I understand that I will be responsible for a charge of $25.00 for missed appointments without at least 24 hour prior cancellation notice and a charge of $100.00 for any missed procedure without at least 48 hour prior cancellation notice; and a $10 Processing fee will be charged if I don't pay my copay at the time of my visit. I certify that the information I provided above is correct.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date* *Signature of Subscriber or Beneficiary*

I acknowledge that I read and agree with the privacy notice of Giath Alshkaki, M.D.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date* *Signature of Patient*

6400 Arlington Blvd, Suite 940 Tel: 703-942-8770

Falls Church, VA 22042 Fax: 703-942-8709

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

Please present you insurance card(s) and your driver’s license to the front office staff so they may make a copy to place in the medical record.

**Insurance Waiver and Financial Notification Statement**

All co-pays and deductibles are expected at the time of service by cash, or credit card. Insurance benefits applicable to this service will be filed by our billing office provided you furnish the necessary identification numbers with the mailing address. All referrals and pre-certification are the responsibility of the patient to make sure they are received by our office before being seen by the physician. If insurance payment is not received in 45 days from the date of filing, it become your responsibility to pay the account in full and look directly to the insurance company for resolution of the claim. Accounts that are not paid in full by 60 days are considered delinquent and are subject to collection by an outside agency. In the event this account is released for collection, any collection and/or attorney’s fees will become the responsibility of the guarantor of the account.

I agree that **Infinity Surgical Associates** are not to file a claim when the insurance information is given after the services are performed and the patient will be fully responsible to pay the amount due.

I agree to pay for services for which I have not provided the correct insurance information prior to the service.

I agree to pay for any services for which I have not obtained a proper referral.

I agree to pay for non-covered services under my insurance plan.

I agree to pay any deductibles, co-pays, or out of pocket expenses per my insurances policy as requested by **Infinity** **Surgical Associates** in a timely fashion.

I agree to pay for any service for which I have not answered my own insurance company’s inquires.

I certify that I have provided complete, current and accurate information regarding my personal, medical and insurance information.

I take responsibility for understanding my coverage by communicating with my insurance company and/or benefits coordinator. Also, I agree that it is my responsibility to make sure that Infinity Surgical Associates are paid for this service.

**Guarantor Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Insurance Benefits**: I hereby authorize payment directly to Infinity Surgical Associates of any and all insurance benefits for this visit, hospital inpatient or outpatient stay, otherwise payable to or on behalf of the patient or to me, and authorize release of information requested by the patient’s insurance company(ies).

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

(Patient or authorized representative)

**Assignment of Medicare and/or Medicaid Benefits**: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.

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

(Patient or authorized representative)

# REQUEST FOR MEDICAL RECORDS/ RELEASE OF INFORMATION FORM

The undersigned patient or patient representative agrees to the following terms regarding all general and specific information transmission, and/or requests that medical records are delivered to the specified location. I understand that a fee may apply for specific requests.

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records Requested:

Any records requested deemed necessary for the pre-operative and post-operative evaluation and management of a patient’s case. Records may be sent to referring physicians, specialists, hospitals, pre-op centers, insurance or financing agencies, or any other entity that needs such information for the patient’s care or other financial purposes. The modality of record delivery may include phone conversation, fax, e-mail, US mail, UPS, or other courier service. I understand that any of these delivery modalities is not perfect and that the records may reach persons or entities other than those requested. I understand that Dr. Alshkaki and his employees are acting in good faith and I certify that I will indemnify and hold Dr. Alshkaki and his employees harmless for any such delivery errors.

**I agree to receive e-mail/faxes regarding my medical condition from my doctor or Dr. Alshkaki. I understand that when I communicate via e-mail, that response times may be significantly slow and delayed and that I will not depend on this modality for time sensitive communication or urgent problems.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Printed Name Patient’s Signature Today’s Date

### OR

I certify that I am legally entitled to sign on behalf of the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s Printed Name Rep.’s Signature Date

6400 Arlington Blvd, Suite 940 Tel: 703-942-8770

Falls Church, VA 22042 Fax: 703-942-8709

**PATIENT RESPONSIBILITY WAIVER**

**NON-COVERED PROCEDURES/SURGERY OR NO REFERRAL**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been made aware

that my insurance company/ies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(NAME OF INSURANCE COMPANY/IES)

May not cover the following procedures:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am and will be financially responsible for all charges/amounts due at the time of service unless other arrangements are made for a payment plan with our office manager and/or billing service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/ Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Personal Signature Date

**Alternative Arrangements for Payment**

Payment for services provided to the patient will be made as follows:

(Describe payment arrangements.)

**PATIENT IS TOTALLY RESPONSIBLE FOR PAYMENT IF SEEN BY PHYSICIAN WITHOUT PROPER REFERRAL. PCP WILL NOT AND CANNOT BACKDATE**

**REFERRALS FOR OFFICE VISITS/PROCEDURES/SURGER**

**Notice of Privacy Practices**

As required by the privacy regulations created as a result of the Health Insurance Probability and Accountability Act of 1996(HIPAA).

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF INFINITY SURGICAL ASSOCIATES) (ISA) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY**.

This Notice describes ISA’s privacy practices and those of:

🙜 Any health care professional authorized to enter information into your ISA chart.

🙜 All locations of ISA.

🙜 All employees, staff and other ISA personnel.

🙜 All of these locations follow the terms of this notice. They may share medical information with each other for treatment, payment or ISA operations purpose described in this notice.

🙜 Any business associate of ISA that performs services for or on behalf of these entities is required by us to enter into a contact in which it undertakes to accord the same level of confidentiality to medical information that we afford.

OUR PRIVACY PRACTICES REGARDING MEDICAL INFORMATION

In order to provide you with quality care and to comply with legal requirements, we create a record of the care and services you receive from us. We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. This notice applies to all of the records of your care generated by us. We are required by law to:

* Make sure that medical information that identifies you is treated confidentially;
* Give you this Notice of Privacy Practice with respect to medical information about you; and
* Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

🙜 **For Treatment**. We may use your medical information to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your medical information in order to write a prescription for you, or we might disclose your medical information to a pharmacy when we order a prescription for you. Many of the people who work for ISA including, but not limited to , our doctors and nurses may use or disclose your medical in order to treat you or to assist others in your treatment. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your medical information to others health care providers for purposes related to your treatment.

🙜 **For Payment.** We may use and disclose your medical information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your medical information to bill you directly for services and items. We may disclose your medical information to other health care providers and entities to assist in their billing and collection efforts.

**To be completed by the patient**

MEDICAL QUESTIONAIRE

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| **MEDICAL HISTORY** |
| Last name First Age  Height (ft / in) Current weight  Occupation  How long at current weight?  Race: □ White □ Black □ Asian □ Native American □ Hispanic |

|  |
| --- |
| **Who is the first person to notify immediately following surgery?** |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: (check where to call) Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Will she / he be waiting at the hospital during your surgery? □Yes □No |

**MEDICATIONS TAKEN**

Current medications: Including vitamins, over the counter medications, and intermittently used drugs.

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| --- | --- | --- | --- | --- | --- | --- |
| Name | Strength | How often taken | Purpose | When use started | Req. | As needed |
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Are you allergic to any medication or foods? □Yes □ No

Please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GHIATH ALSHKAKI, MD, FRCSI.

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| **List any major illnesses** | | | |
| Illness | Date | Treatment | Outcome |
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| **List any Surgeries** | | |
| Surgery | Date | Reason |
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Have you ever had surgery to aid weight loss? □Yes □ No if yes, When? \_\_\_\_\_\_\_\_\_

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| **FAMILY HISTORY**  Check all the applies | | | | | | | | |
| Family Member | Age now or at death | Cause of Death | Thin | Normal Weight | Slightly Overweight | Moderately  Overweight | Markedly  Overweight | Health-Problems |
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Any other family members are obese (indicate Mother’s / father’s side of the family).

**FAMILY HISTORY CONTINUED. . .**

Breast, Colon or Prostrate Cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (specifictype):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart attack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back Trouble: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SHORTNESS OF BREATH** |
| Do you experience shortness of breath with physical activity? □Yes □ No  How long have you been aware of this (be specific)? \_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_\_ years  When walking up stairs, how many steps can you climb before noticing shortness of breath?  \_\_\_\_\_\_\_\_\_\_\_ steps / flights. (Please circle one and indicate how many).  Do you exercise regularly? □Yes □ No  If yes, complete the following:  What type of exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What prevents you from exercising now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

In what position do you sleep? Sitting up Lying flat on back Lying on side lying on stomach

How many pillows do you use under your head? \_\_\_\_\_\_\_\_

Do you awaken from sleep to catch your breath? \_\_\_\_\_\_\_\_

Do you snore? □Yes □ No

Do you ever stop breathing while asleep? □Yes □ No

Do you doze off when you’re talking to someone? □Yes □ No

Have you ever had a sleep study done? □Yes □ No

Do you have or ever had asthma? □Yes □ No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience swelling of the ankles? □Yes □ No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do to decrease the swelling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience chest pain with exercise or activity? □Yes □ No

How long? \_\_\_\_\_\_\_\_\_\_ (yrs / mos)

What do you take to relieve the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid problem? □Yes □ No Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Diabetic □Yes □ No How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you taking for diabetes? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you monitor your blood sugar? □Yes □ No

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have high blood pressure? □Yes □ No

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you taking for your high blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HEARTBURN AND / OR INDIGESTION** |
| Do you have indigestion or heartburn? □Yes □ No  If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years / months  What food or drinks cause digestive problems for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you ever have any type of pain in the abdomen? □Yes □ No  If yes, give details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What relieves the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_What have you tried that did not relieve the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any changes in bowel movements? □Yes □ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any bloody stools? □Yes □ No History of hemorrhoids? □Yes □ No External / Internal |

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| **BONE OR JOINT PROBLEMS** | | | | | | |
| Do you have the following: | | | | | | |
| Locations | Swelling | | Pain | Stiffness | | Popping |
| Ankles |  | |  |  | |  |
| Knees |  | |  |  | |  |
| Hips |  | |  |  | |  |
| Back |  | |  |  | |  |
| Other |  | |  |  | |  |
| Have you ever sought treatment for bone or joint problems or injuries? Give details.  (Including physical therapy and chiropractic) | | | | | | |
| Doctor | | Date of Treatment | | | Diagnosis / Treatment | |
|  | |  | | |  | |
|  | |  | | |  | |
|  | |  | | |  | |
| Have you taken any medications for this problem? If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you consulted a chiropractor? □Yes □ No  Have you ever been told you have degenerative changes or early arthritic changes in your joints? □Yes □ No | | | | | | |

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| **UNINARY PROBLEMS (Females)** |
| Do you ever involuntarily lose your urine? □Yes □ No  If yes, what causes you to loose urine? □ Coughing □ Jumping □ Sneezing □ walking  □bending forward □ laughing  Do you experience pain when urinating? □Yes □ No  Do you wear pads for protection? □Yes □ No How often must you change pads? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How often do you wet your clothing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any history of bladder surgery? □Yes □ No |

**To be completed by the patient**

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| --- |
| REVIEW OF SYMPTOMS |
| Unless otherwise specified. Answer the following referring to your current status. |
| NO YES Details or Comments  Frequent or severe fatigue………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequent or severe Weakness…………….. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fever, chills, night sweats………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequent or severe headaches…………….. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any history or head injury with loss of consciousness \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nasal congestion………………………….. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chronic sinus congestion………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Wheezing………………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Coughing………………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Heart murmur……………………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anemia…………………………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any history of blood transfusion………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bleeding tendency……………………….. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Convulsions, seizures……………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Paralysis…………………………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Numbness or tingling…………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Memory loss……………………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Depression……………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anxiety………………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mood swings…………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sleep problems………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Drug or alcohol abuse…………………. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Chronic skin rash or hives…………….. \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hay Fever……………………………… \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you used tobacco products in the past? □ Yes □ No If yes, how long?\_\_\_\_\_\_\_\_  Do you now use any tobacco products? □ Yes □ No  If yes, how many cigarettes or packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you ever drink alcohol? □ Yes □ No  If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks per day\_\_\_ Week\_\_\_\_\_\_  Do you use caffeine? (coffee, cocoa, cola, chocolates, No-Doz, Aqua Ban).  □ Yes □ No If yes, in what form? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

GHIATH ALSHKAKI, MD, FRCSI.

**To be completed by patient**

**DIETARY HISTORY**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the form as precisely as possible

DIET PROGRAMS: # Times Date(s) Of Time # Lbs #Lbs

Tried Tried On Diet Lost Regained

Example: 3 1999/2002/04 2 – 3 mos ea 5-25 lbs ea All+

Medi-Fast ………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

M.D. Name/Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Opti-Fast ………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

M.D. Name/Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mayo Clinic………. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

HMR……………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_....................... \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Shots: □ B-6 \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ B -12 \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Other\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

M.D./ Clinic Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phen-Fen \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□Phentermine (only) \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Fastin \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Redux \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Meridia \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Xenical \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

M.D. /Clinic Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NON M.D. SUPERVISED

Weight Watchers…. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Nutri-System……… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Jenny Craig……….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Diet Center……….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

TOPS……………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Overeaters Anonymous \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Slimfast…………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Sweet Success……. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Other……………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

GHIATH ALSHKAKI, MD, FRCSI.

Length

DIET PROGRAMS: # Times Date(s) Of Time # Lbs #Lbs

Tried Tried On Diet Lost Regained

MISCELLANEOUS DIETS

Low Calorie Diet…… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Low Fat Diet……….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

High Protein Diet…... \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Self Imposed Diet….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Atkins Diet………… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Scarsdale Diet…….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Pritikin Diet………. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Richard Simmons… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Susan Powter…….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Herbal Life………. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Cambridge Diet….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_...... \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

DIET PILLS (over the counter)

Acutrim……….. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Dexatrim……… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Metabolife……. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Other\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

OTHER TYPES OF WEIGHT LOSS

Psychotherapy…. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Acupuncture…… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Hypnosis………. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Subliminal Tapes \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_... \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

EXERCISE

Health Club…… \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

VCR Tapes……. \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_... \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_

How long have you been overweight? \_\_\_\_\_\_\_\_\_\_ Age of first Diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greatest single weight loss? \_\_\_\_\_\_ lbs How was weight loss obtained?\_\_\_\_\_\_\_\_\_\_\_

How many times have you lost 25 pounds? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a snacker? □ Yes □ No Favorite Foods / snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat a lot of sweets? □ Yes □ No How often do you eat sweets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a physicians care for weight loss? □ Yes □ No

Type of program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Management**

○ **Weight Loss Surgery Benefits**

**○ Call insurance company & employer benefits department to see**

**if you have the weight loss surgery benefits.**

**Insurance** **Pre- Requisites**

Aetna 6 months MD supervised diet w/in the last 2 yrs/ mnthy wgh-in

Alliance Psych Eval, Endocrine Clrnce, Medical Clrnce, Sprvsd Diet

BC BS Diet History failed for over 1 year

Cigna 6 months diet doc w/in last yr. psych Eval.Mtly wgh-in

Mamsi Psych Eval, Supervised diet documentation

(Mail Handlers /First Health) Supervised diet documentation

UHC Supervised diet, Psych Eval

GEHA Psych Eval, Diet History by MD

PHCS 6 Months supervised diet w/in the last year/ mthly wgh-in,  
psych Eval, sprvsd diet doc, Endo Clrnce, Med Clrnce

**Due to the changing requirements from the insurance companies the above information is subject to change frequently.**

GHIATH ALSHKAKI, MD, FRCSI.

**AUTHORIZATION TO SHARE HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, allow my doctor(s), my health plan or insurers, and any

Other healthcare providers to give medical information relating to my use or need for the

Adjustable Gastric Band .Or other Bariatric Procedures

This information can include spoken or written facts about my health or payment benefits I may have.

It can include copies of records from my healthcare providers or health plans about my health or care.

The information will use and give out this information to check to see if I Have coverage for Adjustable Gastric Band or other procedures.

Healthcare Consultants will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it. This Authorization will last for 3 years after the date I sign this form. If I change my mind before that time, I can tell my doctor, healthcare provider, and/or my insurer in writing that I do not want them to share any more information.

I will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers.

Patient Sign Here/ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If the patient cannot sign, patient's representative must sign below)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of person signing for patient)

Describe relationship to patient and right to act for patient:

GHIATH ALSHKAKI, MD, FRCSI.

**Patient contract**

**The purpose of this Agreement is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.**

*Instructions: Please read each paragraph, and once you agree to the contents of that paragraph, please write your initials on the line underneath the paragraph. If you have any questions as to the meaning of any paragraph, please ask your physician to explain it to you.*

\_\_\_\_ I understand that this Agreement is essential to the trust and confidence necessary in a physician-patient relationship.

\_\_\_\_ I understand that if I do not follow through with all of the terms of this Agreement, my physician may refuse to perform

bariatric surgical procedure or may discharge me as a patient from the practice at anytime.

\_\_\_\_ I understand that my care and treatment may include use of prescription drugs such as narcotics for pain control. I agree that if I

misuse the drugs prescribed for me, my physician may terminate my care and treatment. Misuse includes altering prescriptions, taking other than the prescribed dosage, or using fraudulent or illegal means to obtain drugs.

\_\_\_\_ I will fully communicate to my physician or other applicable healthcare provider any concerns or any suspected complications after the surgery.

\_\_\_\_ I agree to comply with the pre- and post-surgery protocols, which includes following the diet(s) provided to me, and behavior modification.

\_\_\_\_ I agree to keep my follow-up appointments as recommended by my surgeon and/or primary care physician.

\_\_\_\_ I agree to take my vitamins, and calcium and other supplements for life as directed by my surgeon and/or primary care physician.

\_\_\_\_ I agree to have blood work done for life on an at least annual basis.

\_\_\_\_ I agree to see my surgeon and family physician as directed. It is my responsibility to provide both of them with records from these visits.

\_\_\_\_ Any medical condition that exists or may develop, not in direct relationship to the weight reduction surgery, must be treated by my primary care physician (and/or appropriate specialty physician) and I agree to coordinate my care with my surgeon. I understand that my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

\_\_\_\_ I understand that successful long-term weight loss is depends on following the principles and guidelines of my surgeon’s bariatric surgery program.

\_\_\_\_ I verify that I have completed a medical history questionnaire and that to the best of my knowledge it is true and correct.

**I have read all medical forms and discussed any questions that I may have with my surgeon.**

Patient Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS:

□ the patient/Authorized Representative has read the form or had it read to him/her

□ the patient/Authorized Representative expresses understanding of the form

□ the patient/Authorized Representative has no questions

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**USE OF INTERPRETER OR SPECIAL ASSISTANCE**

An interpreter or special assistance was used to assist patient in completing this form as follows:

\_\_\_\_\_\_\_ Foreign language (specify)

\_\_\_\_\_\_\_ Sign language

\_\_\_\_\_\_\_ Patient is blind, form read to patient

\_\_\_\_\_\_\_ other specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpretation provided by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Fill in name of Interpreter and Title or Relationship to Patient)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Individual providing assistance)