SURGICAL WEIGHT LOSS

Patient Packet

Med Center Health
Medical Center
Surgical Weight Loss Program

Revised 1/19
We have helped hundreds of people just like Carissa meet their weight loss goals. A healthy weight can significantly improve your quality of life and may decrease the need for medicines to treat weight-related conditions.

If you have thought about weight loss surgery, take the next step! Join us for a free informational seminar where we will discuss surgery options, and the benefits and risks of each. An insurance specialist is available to discuss costs, insurance coverage and financing options.

Register online at TheMedicalCenter.org/SWLP. If you have questions, please call 270-796-6333.

“I have struggled with my weight all my life. I never had a problem dieting and losing weight, I just couldn’t keep it off. I am now able to do so many things I couldn’t do before—things that people take for granted. Having surgery is a life-changing experience, but you have to put your whole heart into it and make lifestyle changes.”

CARISSA
**Preferred Procedure:**
- ☐ Laparoscopic Sleeve Gastrectomy
- ☐ Laparoscopic Roux-en-Y Gastric Bypass

**Are you able to read, write and communicate in the English Language?**  ☐ YES  ☐ NO

If not, what is your primary language?

Please list any other barriers to communication, or special accommodations that you require:

**Patient Information:**

**First Name:** ___________________  **Middle Name:** ___________________  **Last Name:** ___________________

**Social Security Number:** _____________  **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):** ___________________

**OK to leave message at:**  ☐ Home  ☐ Work  ☐ 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? _____________________________

Spouse Information:
Spouse’s Name: _____________________________ Spouse’s Date of Birth: _____________________________

<table>
<thead>
<tr>
<th>Spouse’s Employment Status:</th>
<th>○ Full Time</th>
<th>○ Retired</th>
<th>○ Disabled</th>
<th>○ Student</th>
<th>○ Part Time</th>
<th>○ Unemployed</th>
<th>○ Homemaker</th>
<th>○ Leave of Absence</th>
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<tbody>
<tr>
<td>Spouse’s Occupation:</td>
<td>_____________________________</td>
<td>Spouse’s SSN: _____________________________</td>
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<td>Spouse’s Employer:</td>
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<td>Years Employed: _____________________________</td>
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<tr>
<td>Spouse’s Employer’s address:</td>
<td>_____________________________</td>
<td>Spouse’s Cell Phone: _____________________________</td>
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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 The Medical Center to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s)":
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: ______________________________

Please list all Specialist Providers:

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<tr>
<th>Provider Name</th>
<th>Telephone Number</th>
<th>Specialty</th>
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Weight Loss History: Greatest weight in the past 12 months?___________ Date of greatest weight?________________
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  ☐ Prozac
☐ Wellbutrin  ☐ Amphetamines  ☐ Didrex  ☐ Phentrol
☐ Redux  ☐ Byetta  ☐ Plegine  ☐ 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?
___________________________________________

___________________________________________
What is your greatest fear regarding surgery?

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

### General:
- [ ] NONE
- [ ] Fevers
- [ ] Night Sweats
- [ ] Appetite Change
- [ ] Weight Gain
- [ ] Insomnia
- [ ] Hair Loss
- [ ] Tired / No Energy
- [ ] Other:

### Head and Neck:
- [ ] NONE
- [ ] Wear contacts / glasses
- [ ] Sinus Drainage
- [ ] Dentures, Partial / Full
- [ ] Regular Ear Infections
- [ ] Vision Problems
- [ ] Nose Bleeds
- [ ] Allergies
- [ ] Blurred / Double Vision
- [ ] Other:

### Cardiovascular:
- [ ] NONE
- [ ] Heart Attack
- [ ] Congestive Heart Failure
- [ ] Varicose Veins
- [ ] Ankle / Leg Ulcers
- [ ] Clogged Heart Arteries
- [ ] Irregular Heart Beat
- [ ] Atrial Fibrillation
- [ ] Chest Pain w/ Activity
- [ ] High Blood Pressure
- [ ] Dyspnea on Exertion
- [ ] Elevated Triglycerides
- [ ] Rheumatic Fever / Valve Damage / MVP
- [ ] Cramping in legs when walking
- [ ] Elevated Cholesterol
- [ ] Other:

### Respiratory:
- [ ] NONE
- [ ] Asthma
- [ ] Pneumonia
- [ ] Use of Cpap / Bipap
- [ ] Pulmonary Embolism
- [ ] Emphysema / COPD
- [ ] Chronic Cough
- [ ] Use of Oxygen
- [ ] Sleep Apnea
- [ ] Bronchitis
- [ ] Shortness of Breath at Rest
- [ ] Snoring
- [ ] Other:

### Gastrointestinal:
- [ ] NONE
- [ ] Heartburn
- [ ] Diarrhea
- [ ] Constipation
- [ ] Difficulty Swallowing
- [ ] Rectal Bleeding
- [ ] Abdominal Pain
- [ ] Gallbladder Problems
- [ ] Nausea / Vomiting
- [ ] Barrett’s Esophagus
- [ ] Hiatal Hernia
- [ ] Blood in Stool
- [ ] IBS
- [ ] Hemorrhoids
- [ ] Black, Tarry Stool
- [ ] Enlarged Liver
- [ ] Jaundice
- [ ] GERD
- [ ] Ulcers
- [ ] History of Liver Enzymes
- [ ] Umbilical Hernia
- [ ] Fissure / Polyps
- [ ] Ventral Hernia
- [ ] Cirrhosis / Hepatitis
- [ ] Pancreatic Disease
- [ ] Incisional Hernia
- [ ] Other:

### Bladder/Kidney:
- [ ] NONE
- [ ] Kidney Stones
- [ ] Kidney Failure / Renal Insufficiency
- [ ] Blood in Stool
- [ ] Leaking urine w/ cough/laugh/sneezing
- [ ] Men: PSA test in last year?
- [ ] Blood in Urine
- [ ] Prostate Problems
- [ ] Other:

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Revised 1/19
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Options</th>
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<tbody>
<tr>
<td>Trouble starting urine</td>
<td>□ Burning / Pain on urination □ Urinary Urgency/Frequency</td>
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<tr>
<td>Overall Loss of Bladder Control</td>
<td>□ Other: __________________________________________________________________________________</td>
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**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

How many pregnancies have you had: ____________________________
How many miscarriages or abortions have you had: ____________________________

**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
- □ Pseudotumor 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 □ Seen a Psychiatrist or Counselor
- □ Bipolar Disorder ("manic-depression") □ Been hospitalized for psychiatric problems
- □ Alcoholism / Substance Abuse □ Attempted suicide
- □ Been in a chemical dependency program □ Victim of Mental/Emotional/Sexual/Physical Abuse
- □ Currently taking medications for psychiatric problems or for depression □ Other: __________________________________________________________________________________
- □ Attention Deficit Disorder

**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
- □ Other: __________________________________________________________________________________
### Blood/Lymphatic:
- Low Platelets (thrombocytopenia)
- Bruise Easily
- Bleeding/Clotting Disorder
- Prior Blood Transfusion
- Anemia
- Lymphoma
- Blood thinning medicine use
- HIV / AIDS
- Swollen Lymph Nodes
- History of DVT / PE

#### Blood/Lymphatic:
- Low Platelets
- Bruise Easily
- Bleeding/Clotting Disorder
- Prior Blood Transfusion
- Anemia
- Lymphoma
- Blood thinning medicine use
- HIV / AIDS
- Swollen Lymph Nodes
- History of DVT / PE

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

### List Prescribed Medications:
- **Taken for what condition:**
- **Dosage/How Often:**

<table>
<thead>
<tr>
<th>Product</th>
<th>Taken for what purpose</th>
<th>Dosage/How Often</th>
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### 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:**

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<thead>
<tr>
<th>Product</th>
<th>Taken for what purpose</th>
<th>Dosage/How Often</th>
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### Allergies:
- **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:**
<table>
<thead>
<tr>
<th>Surgical Procedure(s):</th>
<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td>Galbladder (Open)</td>
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<td>Tonsillectomy</td>
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<tr>
<td>Galbladder (Laparoscopic)</td>
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<td>D &amp; C</td>
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<tr>
<td>Appendectomy (Open)</td>
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<td>Ear Surgery:</td>
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<tr>
<td>Appendectomy (Laparoscopic)</td>
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<td>Mouth Surgery:</td>
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<tr>
<td>Hysterectomy (Vaginal)</td>
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<td>Heart surgery: CABG/Stents</td>
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<td>Hysterectomy (Abdominal)</td>
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<td>Valve Replacement</td>
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<td>Ovary Surgery:</td>
<td>Ovaries Removed</td>
<td>Pacemaker</td>
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<td>Hernia:</td>
<td>Hiatal</td>
<td>Umbilical</td>
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<td>Tubal Ligation</td>
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<td>Breast Biopsy: Right Left</td>
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<td>Cesarean Section</td>
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<td>Anti-reflux procedure / Nissen Fundoplication</td>
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<td>Colonoscopy</td>
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<td>Kidney Surgery</td>
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<td>Colostomy</td>
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<td>Other:</td>
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<td>Colon Resection</td>
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<td>Other:</td>
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<tr>
<td>Endoscopy</td>
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</table>

**Anesthesia Problems:** Please tell us about any problems that you have had with anesthesia:

- [ ] Nausea
- [ ] Heart Stopped
- [ ] Woke up during procedure

- [ ] Vomiting
- [ ] Stopped Breathing
- [ ] Difficulty Waking Up
- [ ] Difficulty Urinating
- [ ] Other: __________________________

**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?
  - [ ] Yes
  - [ ] No
  - If yes, how many times per week?
  - [ ] Yes
  - [ ] No
  - If you consume alcohol now?
  - [ ] Yes
  - [ ] No
  - If yes, how many drinks each time?
  - [ ] Yes
  - [ ] No
  - If you use street drugs now?
  - [ ] Yes
  - [ ] No
  - If yes, how frequently do you use these drugs?
  - [ ] Yes
  - [ ] No
  - If yes, how many hours a day do you watch TV?
  - [ ] Yes
  - [ ] No
  - If you are the primary care giver?
  - [ ] Yes
  - [ ] No
  - Who?

- Do you use snuff or chew?
  - [ ] Yes
  - [ ] No
  - If yes, how many years did you use tobacco?
  - [ ] Yes
  - [ ] No
  - If you consume alcohol now?
  - [ ] Yes
  - [ ] No
  - If yes, how many drinks each time?
  - [ ] Yes
  - [ ] No
  - If you watch TV?
  - [ ] Yes
  - [ ] No
  - If you are the primary care giver?
  - [ ] Yes
  - [ ] No
  - Who?

- Is anyone concerned about the amount you drink?
  - [ ] Yes
  - [ ] No
  - If you have quit, how many years since?
  - [ ] Yes
  - [ ] No
  - If you use street drugs now?
  - [ ] Yes
  - [ ] No
  - If yes, how frequently do you use these drugs?
  - [ ] Yes
  - [ ] No
  - If you have quit, how many years since?
  - [ ] Yes
  - [ ] No
  - If you watch TV?
  - [ ] Yes
  - [ ] No
  - If you are the primary care giver?
  - [ ] Yes
  - [ ] No
  - Who?
On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life.

Married Life? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Present job/activities? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Overall satisfaction with yourself? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Family Medical History: (Check all that apply)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Mother</th>
<th>Father</th>
<th>Siblings (specify brother or sister)</th>
<th>Maternal Grandmother</th>
<th>Maternal Grandfather</th>
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<td>Morbid Obesity</td>
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<td>Diabetes- Age Occurred</td>
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<td>High Blood Pressure</td>
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<td>Stroke- Age Occurred</td>
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<td>Cardiovascular Disease</td>
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<td>Sleep Apnea</td>
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<td>Cancer: Type &amp; Age Occurred</td>
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<td>Death- Age &amp; Cause</td>
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<tr>
<td>If Still Living, what age</td>
<td></td>
<td></td>
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</tbody>
</table>

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

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

☐ Filled out this form as completely as possible
☐ Made a copy of the front and back of your insurance card
☐ Called your insurance and completely fill out the Insurance Review Form (next page)

Date Completed: __________________________

Mail completed packet and Insurance Card to:

Medical Center Surgical Weight Loss Program
Riverside Professional Center
825 Second Ave, Suite A4
Bowling Green, Kentucky 42101
Phone: 270-796-6333
Fax: 270-780-2793
(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare but it does need to be filled out for Medicare Replacement, Medicare HMO and Medicare Supplements.**)

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

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Fill in this information before you call the insurance company. Please write clearly.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Date of Birth</th>
<th>Insurance Name</th>
<th>ID Number</th>
<th>Group Number</th>
<th>Subscriber Name</th>
<th>Subscriber Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Question for Representative</th>
<th>Answer from Representative</th>
</tr>
</thead>
</table>
| 1 | Please look in my current year certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary? | □ Yes (Continue with this form.)  
|   | □ No (Complete #s 2, 25, & 26 then end the call.) |

**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.**

<table>
<thead>
<tr>
<th>2</th>
<th>Please have the representative read the benefit or exclusion to you. Write it down word for word.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Do I have a Bariatric Lifetime Max?</td>
</tr>
</tbody>
</table>
| 4 | Am I required to have Weight Loss Surgery at a Center of Excellence facility or Blue Distinction Center?  
|   | Center of Excellence: □ Yes □ No  
|   | Blue Distinction: □ Yes □ No |
| 5 | Is The Medical Center, Bowling Green, Kentucky in my network? Tax ID #: 043665929 |

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Revised 1/19
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>What is the effective date of my policy?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>What is the calendar year renewal date?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do I have a pre-existing clause?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>If yes, what is the end date of the pre-existing clause?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is a referral required?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>What is the deductible per calendar year?</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>How much have I met towards my deductible?</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>What is the maximum out of pocket per calendar year?</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>How much have I met towards my maximum out of pocket?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Is the deductible applied to the maximum out of pocket?</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>What is the co-insurance percent for my policy?</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>What are my financial obligations to the doctor for inpatient surgery?</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>What are my financial obligations to the doctor for outpatient surgery?</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>What are my financial obligations to the hospital for inpatient surgery?</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>What are my financial obligations to the hospital for outpatient surgery?</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>What is my copay for a primary care office visit?</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>What is my copay for a specialist office visit?</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>What is the fax number for pre-determination?</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Name of the representative</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Date you spoke to representative</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td><strong>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.</strong></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Disclaimer:**
- The Medical Center 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 The Medical Center.

**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:** ___________________________