NEW LIFE
WEIGHT LOSS & ADVANCED LAPAROSCOPIC SURGERY

317 S. 14th Street, Suite 1 Herrin, IL 62948
Telephone (618)988-6171 Facsimile (618)351-6491

PAPERWORK REQUIRED FOR YOUR FIRST OFFICE VISIT

All of the information listed below is required at your first office visit. This information is located in your Information Session packet. Please use this as a check list to make sure you have everything that is required.

BE AWARE that if you do not bring the necessary, completed information, your first office visit WILL BE RESCHEDULED. NO EXCEPTIONS.

- ❑ **Medical History Questionnaire**
- ❑ **Diet and Nutrition History Questionnaire** Must be filled out as completely as possible including dates and weight lost/gained.
- ❑ **Sleep History Questionnaire**
- ❑ **Patient Information Sheet**
- ❑ **Primary Care Physician Referral Form** – Have this form completed by your doctor, with the doctor's signature, address and phone number completed.
- ❑ **Consent for Release of Medical Information**
- ❑ **Pre-Operative Immunization Waiver Form**
- ❑ **Insurance Review Form & Insurance Cards** – We will be taking a copy of the front and back of each card for proper billing to your insurance company at the time of your first visit.
- ❑ **In addition to the completed information, you will be required to bring with you:** Your Support Person, a photo ID, your current insurance card(s), a referral from you primary care physician, and your office visit copay.

Once you have all forms completed, please contact our office at 618-988-6171 to schedule your first office appointment.

1. **You MUST bring your entire completed packet to your first office visit. Please DO NOT fax or mail any paperwork prior to your first office visit.**
2. **Your co-pay or applicable deductible amounts required by your insurance.**

Please note: We have included the Psychological Assessment information for you to review. While this assessment ***does not*** need to be completed prior to your first visit, some patients find it beneficial to complete this step early in the process.

Patients who have had previous Weight Loss Surgery: Please have your operative report and follow up documentation forwarded from your original surgeon to our office for review. You will be contacted to schedule an appointment after your records have been reviewed and accepted. **We are unable to schedule an appointment for you until your information has been received and reviewed.**

Thank you for your cooperation in this process.

SIH MEDICAL GROUP

New Patient History Form

PATIENT INFORMATION

Patient Name (Last, First, Middle)	SSN#	Birth date	Language	Sex

Address	City, State, Zip	Referring Physician	Secondary Address	Ethnicity

Home Phone	Day Phone	Email Address	Primary Care Prov	City State Zip	Race

Marital Status	Smoker (Y/N?)	Veteran (Y/N?)	Emergency Contact Name	Contact Phone	Home Phone

Primary Employer & Occupation	Secondary Employer (If Applicable)

Address	Address

City, State, Zip	City, State, Zip

RESPONSIBLE PARTY INFORMATION (If different than above)

Name (Last, First, Middle)	SSN#	Birth date	Language	Sex

Address	City, State, Zip	Secondary Address

Home Phone	Day Phone	Email Address	City, State, Zip

Marital Status	Veteran (Y/N?)	Primary Care Physician	Home Phone

Relationship to Patient	

PRIMARY INSURANCE

Name of Insurance Company	Policy #	

Name of Insured	Group #	

Address of Insurance Company	Copay Amt $	

City, State, Zip	Phone	Deductible $	

Relationship to Patient	Effective Date	Expiration Date

SECONDARY INSURANCE (If applicable)

Name of Insurance Company	Policy #	

Name of Insured	Group #	

Address of Insurance Company	Co pay Amt $	

City, State, Zip	Phone	Deductible $	

Relationship to Patient	Effective Date	Expiration Date

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Medical History Questionnaire

Date: / /

Name: _____ Birthdate / /

Height: ft. in. Weight: lbs BMI: Age: _____

Life Satisfaction: 1 2 3 4 5 (1 being least happy - 5 being very happy)

Diet and Nutrition History

ou must include weight loss and dates for all diet attempts within the last 3-4 years. You may add additional lines/page

MD Supervised Programs	How Long	Pounds Lost	Dates (mm/yyyy)
Medi-Fast			__/____ to __/____
Opti-fast			__/____ to __/____
New Start			__/____ to __/____
Commercial Diets	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Weight Watchers			__/____ to __/____
Diet Workshop			__/____ to __/____
Jenny Craig			__/____ to __/____
Overeaters Anonymous			__/____ to __/____
TOPS			__/____ to __/____
Nutrisystem			__/____ to __/____
Prescription Weight Loss	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Redux (dexfenfluramine)			__/____ to __/____
Pondimin (fenfluramine)			__/____ to __/____
Fen/Phen			__/____ to __/____
Phentermine/Fastin/Adipex			__/____ to __/____
Meridia			__/____ to __/____
Zenical			__/____ to __/____
Liquid Diets	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
HMR			__/____ to __/____
SlimFast			__/____ to __/____
Herbal & Non-Prescription	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Ephedra / Ma Huang			__/____ to __/____
Accutrim			__/____ to __/____
Dexatrim			__/____ to __/____
Diurex			__/____ to __/____
Relacore			__/____ to __/____
Cortaslim			__/____ to __/____
Therapy & Other Programs	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Behavior Therapy			__/____ to __/____
Psychotherapy			__/____ to __/____
Exercise Programs			__/____ to __/____
Fitness Centers			__/____ to __/____
Medical & Healthcare Treatments	**How Long**	**Pounds Lost**	**Dates (mm/yyyy)**
Other Surgery			__/____ to __/____
Acupuncture			__/____ to __/____
Hypnosis			__/____ to __/____

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Miscellaneous Diets	How Long	Pounds Lost	Dates (mm/yyyy)
Atkins Diet			___/_____ to ___/_____
Grapefruit Diet			___/_____ to ___/_____
Cabbage Soup Diet			___/_____ to ___/_____
Self-Imposed Fast			___/_____ to ___/_____
Herbal			___/_____ to ___/_____
Low Calorie			___/_____ to ___/_____
Low Fat			___/_____ to ___/_____
Low Sugar			___/_____ to ___/_____
Book / Magazine			___/_____ to ___/_____
High Protein			___/_____ to ___/_____
The Zone			___/_____ to ___/_____
South Beach			___/_____ to ___/_____
Mayo Clinic			___/_____ to ___/_____
Blood Type Diet			___/_____ to ___/_____
Body For Life			___/_____ to ___/_____
Sugar Busters			___/_____ to ___/_____

Obesity History

Years at current weight? _____
Years at 35 pounds overweight? _____
Years 100 pounds overweight? _____

Age patient started to diet? _____
Maximum weight reached? _____

Most significant weight loss

Amount of weight lost _____
Months weight loss sustained _____
Method of weight loss _____

Eating Habits

Volume Eater	Yes/No
Sweet eater	Yes/No
All day long?	Yes/No
Snacker/Grazer	Yes/No

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Past Medical History (Circle all that you have been diagnosed with)

Angina	Deep venous thrombosis	Gout	Peptic Ulcer
Anxiety	Diabetes Type 1 (controlled)	Heartburn	Peripheral edema
Arthritis	Diabetes Type 1 (uncontrolled	Hemorrhoids	Peripheral vascular disease
Arthritis Rheumatoid	Diabetes Type 2 (controlled)	Hypercholesterolemia	Pulmonary embolism
CAD (no CABG)	Diabetes Type 2 (uncontrolled	Hypertension	Sleep Apnea
CAD (CABG)	Dyspnea with exertion	Hypothyroidism	Sleep disorder
Cardiomyopathy	Elevated liver enzymes	Inflammatory Bowel Disease	Snoring
Chest pain with exertio	Fatty Liver (nonalcholic)	Joint Pain	Thrombophlebitis
Cholelithiasis	Fibrocystic Breast Disease	Lower Extremity Edema	Other: _____
CVA	Fibromyalgia	Myocardial Infarction	Other: _____
Depression	GERD	Osteoarthritis	Other: _____

Please list all past surgical procedures and year performed:_____

_____

_____

Family History

Please Circle Yes or No/ If you answer yes to deceased please list age of death and cause.

Family Member	Mother	Cause of Death	Father	Cause of Death	Sister	Cause of Death	Brother	Cause of Death
Alive and Well	Yes/No		Yes/No		Yes/No		Yes/No	
Deceased	Yes/No		Yes/No		Yes/No		Yes/No	
Anemia	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Cancer	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
	Type:		Type:		Type:		Type:	
CVA/Stroke	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Diabetes	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
	Type 1 / Type 2		Type 1 / Type 2		Type 1 / Type 2		Type 1 / Type 2	
Hypertension	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Obesity	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Renal disease	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Cardiovascular	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Arthritis	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
High Cholesterol	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Sleep Apnea	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other:	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other:	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other:	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

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Current Medications

Please refer to your medication bottle for correct strength and dosage. Please list all vitamins and supplements last.

Name of Medication	Strength	How many times per	Why do you take the medication?
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	
	____ mg/mcg/____	Daily, 2x per day, 3x per day, 4x per day, _______ per day	

Allergies

Drug Name	Reaction

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Sleep History Questionnaire

Symptoms During Sleep

Check All That Apply:

- — Loud Snoring
- — Gasping
- — Daytime Sleepiness
- — Difficulty falling asleep
- — Difficulty staying asleep
- — Awaken too early
- — Inability to concentrate
- — Fatigue
- — Morning headaches
- — Irritability / Depression
- — Sleep talking or sleep walking
- — Sinus symptoms interfere with sleep
- — Heartburn, indigestion, sour taste
- — Inability to move while going to sleep or waking up
- — Vivid or life-like visions (people in room, etc.) while going to sleep or waking up.
- — Sudden weakness/feel your body go limp when angry or excited
- — Irresistible urge to move legs or arms
- — Creeping or crawling sensation in legs before falling asleep
- — Legs or arms jerking during sleep
- — Frequent urination disrupting sleep
- — I worry that I won't be able to fall asleep

Sleep Habits

1. At what time do you usually get to bed? _____
2. How long does it take to fall asleep after lights out? _____
3. How often do you awaken at night? _____
4. Total time spent awake in bed? _____
5. I usually wake up at: _____
6. Total length of naps daily? _____
7. Do you work a rotating shift? _____
8. Do you have an unusual work schedule? _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these things, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation

0=would never doze 1=slight chance 2=moderate chance of dozing 3=high chance of dosing

Sitting and Reading _____
Watching TV _____
Sitting, inactive, in a public place (ie. Movie Theater or a meeting) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting & talking with someone _____
Sitting quietly after lunch w/alcohol _____
In a car, while stopped for a few _____

Total Points _____

Which Bariatric procedure do you wish to pursue? (Please Circle)

Laparoscopic Roux-en-Y Divided gastric Bypass
Laparoscopic Gastric Sleeve

PRIMARY CARE PHYSICIAN REFERRAL FORM

(Must be filled out by your physician)

Dear New Life Weight Loss & Advanced Laparoscopic Surgery,

I am referring my patient _____, date of birth _____, to you for your opinion regarding the possibility of weight loss options, including surgery. The patient's current weight is: _____lbs, height is: ____ft ____in, BMI is: _____kg/msq. The patient has been morbidly obese for _____ years.

The patient suffers from the following co-morbid conditions associated with morbid obesity which include: *(check all that apply)*:

- ❑ Type 2 diabetes – controlled by oral medications
- ❑ Type 2 diabetes – controlled by injectable medications
- ❑ Obstructive sleep apnea
- ❑ Coronary artery disease _____
- ❑ Valvular heart disease
- ❑ Hypertension
- ❑ Dyslipidemia
- ❑ Stress incontinence
- ❑ GERD
- ❑ Heart burn
- ❑ Arthritis
- ❑ History of medical non-compliance

The patient also has the following conditions that are associated with morbid obesity:

_____ _____ _____

The patient has a current/history of:

- ❑ Schizophrenia, psychosis, thought disorders
- ❑ Consistent difficulty in coping with stress
- ❑ Suicide attempts or psychiatric hospitalizations
- ❑ Substance abuse or eating disorders

I have completed the following diagnostic work up on this patient **in the past year**. I will be forwarding a copy of these reports to your office to assist with your evaluation of my patient *(please check all that apply)*:

- ❑ Sleep study
- ❑ Exercise Stress Test
- ❑ Laboratory testing such as a lipid panel and Hgb A1C
- ❑ Pulmonary function test
- ❑ Venous duplex
- ❑ Other: _____

The patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. Please render your opinion on appropriate management options.

Sincerely,

_____ _____ (_____)_____

Signature (required) *Date* *Phone*

_____ _____

Printed Name

_____

_____

Address (required)

Please attach the most recent Office Visit Note which includes current medications, medical and surgical history

SIH MEDICAL GROUP

Pre-Operative Immunization Waiver Form

Due to the non-emergent nature of your operation we believe that taking preventative measures to address possible infections prior to hospitalization is important. Please indicate below if you meet the criteria and have had the following vaccines, when and where they were administered.

Criteria: Patients 6 months and older.

☐ I have received an influenza vaccine during the current year's flu season.

Location Received:_____ Date Received:_____

Criteria: Patients 65 years of age and older, OR, between ages of 5 and 64 years and considered high risk. *(High Risk patients include those with Diabetes, Nephrotic Syndrome, End Stage Renal Disease, CHF, COPD, HIV or Asplenia, as well as patients age 19-64 with Asthma)*

☐ I meet the criteria and have received a pneumococcal vaccine in the past.

Location Received:_____Date Received:_____

Declining of Vaccinations

I understand that influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications. I decline the vaccinations prior to my upcoming surgery due to one of the following reasons.

- Hypersensitivity to eggs or other component(s) of the vaccine
- History of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination
- I have had a bone marrow transplant within the past 6 months
- Anaphylactic latex allergy
- I do not wish to obtain the influenza vaccine for personal or religious reasons.

Patient (Legal Representative) Signature:_____

I meet the criteria for the pneumococcal vaccine and understand that multiple studies have demonstrated the effectiveness of the vaccine against the pneumococcal bacteremia. I choose to decline the vaccination at this time due to one of the following reasons.

- Hypersensitivity to component(s) of the vaccine
- I have had a bone marrow transplant within the last 12 months
- Receipt of chemotherapy or radiation during the last 2 weeks
- I have received the shingles vaccine within the last 4 weeks

Patient (Legal Representative) Signature:_____

Patients please be advised that you will be asked about your desire for these vaccinations again once you are at the hospital and will have the opportunity to decline/accept at that time.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ hereby authorize _____ to
(Person Signing Authorization) (Healthcare Provider)

furnish the following medical information to ____New Life Weight Loss & Advanced Laparoscopic Surgery_____

317 S. 14th Street, Herrin, IL 62948 Tel: 618-988-6171 Fax: 618-351-6491
(Name and Address of Receiving Party)

Purpose of disclosure: ☐ Request of individual ☐ Other _____

Patient Name: _____ Date of Birth: _____

Specific Information to be Released: Date of Treatment: _____

- ☐ Lab Report
- ☐ Pathology Report
- ☐ Imaging Report
- ☐ EKG
- ☐ Immunization Record
- ☐ Physical
- ☐ Office Visit Note
- ☐ Other_____

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months or _____.
(Date)

I understand that the information (excluding mental health information) that is being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer be protected under the Heath Insurance Portability and Accountability Act.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree that a photocopy of this authorization is as valid as the original.

Signed _____ Date: _____
(Patient/Representative)

If signed by other than the patient, please indicate relationship and why patient did not sign: _____

_____

Witness: _____ Date: _____
(SIMS Employee)

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INSURANCE REVIEW FORM

This form is for patients with COMMERCIAL insurance plans to help you determine whether or not your insurance policy has benefits for weight loss surgery. **Patients with Medicare and/or Medicaid do not need to complete this form.**
Please follow the instructions below.

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, bring this form, along with a copy of your insurance card(s), to your first visit in our office.
7. 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.

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

#	Question for Representative	Answer from Representative
1	Please look in my current 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.) **See explanation below
****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**		
2	Please have the representative read the benefit **OR** exclusion to you. Write it down word for word. This will tell you what documentation is required to prove medical necessity. (i.e. Physician Supervised Diet, Psych evaluation, BMI criteria, etc.)	
3	Am I required to have Weight Loss Surgery at a Center of Excellence facility?	
4	Is New Life Weight Loss/SIH Medical Group (Dr. Naresh Ahuja) in my network? Tax ID#: 205521741	

5	Is Herrin Hospital/Southern Illinois Healthcare in my network? Tax ID #: 370618939	
6	What is the effective date of my policy?	
7	What is the calendar year renewal date?	
8	Do I have a pre-existing clause?	
9	If yes, what is the end date of the pre-existing clause?	
10	Is a referral from my Primary Care Physician required?	
11	What is the deductible per calendar year?	
12	How much have I met towards my deductible?	
13	What is the maximum out of pocket per calendar year?	
14	How much have I met towards my maximum out of pocket?	
15	Is the deductible applied to the maximum out of pocket?	
16	What is the co-insurance percent for my policy?	
17	What are my financial obligations to the doctor for inpatient surgery?	
18	What are my financial obligations to the doctor for outpatient surgery?	
19	What are my financial obligations to the hospital for inpatient surgery?	
20	What are my financial obligations to the hospital for outpatient surgery?	
21	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
23	Does Physical Therapy require pre-certification?	
24	What is my copay for a specialist office visit?	
25	What is the fax number for pre-determination?	
26	Name of the representative	
27	Date/Time you spoke to representative	
28	**If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.**	☐ **Yes** ☐ **No**

Disclaimer:

- New Life Weight Loss Center and Herrin Hospital are 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 New Life Weight Loss 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:** _____

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DO NOT SMOKE BEFORE OR AFTER BARIATRIC SURGERY!!!!!!

Smoking has been linked as a cause of stomach ulcers and blood clots after bariatric surgery.

You must stop smoking at least one month before surgery.

We will not perform the surgery if you continue to smoke!!!

If you are interested in information or resources to help you quit smoking, please call:
Illinois Tobacco QuitLine: (866) QUIT-YES or www.lungil.org
National QuitLine: (800) QUIT-NOW
SIU Smoking Lab: (618) 453-3561
American Cancer Society: (618) 998-9898