

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS

Surgical and Medical Weight Loss
3830 Washington Rd. Suite 17,
Martinez, GA 30907
(Bariatric Surgery Paperwork)

Have you ever been a patient in this office for any doctor: Yes No

Patient's Full Name: _____
(please print) (First) (Middle) (Last) (name called)

Mailing Address: _____
(Street/apt #) (City) (State) (Zip)

(Date of Birth) (Age) (Sex) (Ethnicity)

(Area Code) (Phone #) (Cell #) (Work #)

(Social Security #) (Employer)

(Email Address) (Pharmacy/Pharmacy Phone #)

(Marital Status) (Spouse's Name)

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

Are you responsible for making decisions for another adult? Yes No

Please state reason for seeing doctor today: _____

Dr. that referred you here: _____ **Primary Care Physician:** _____

Emergency Contact Name: _____ **Phone:** _____

Relationship to Patient: _____ **2nd ph #:** _____

Primary Insurance Co: _____ **Insured:** _____

Secondary Insurance Co: _____ **Insured:** _____

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

HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this information. We are counting on you to provide accurate health history information.

Name:	Age:	DOB:
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Current Height:	Current Weight:
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Allergies:

Problems with anesthesia Latex or tape allergy

Food; Please specify: _____

Medication(s); Please specify: _____

History (please do not write in this space):

CURRENT MEDICATIONS

Medication	Strength/Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

PAST MEDICAL HISTORY				
Past/Current Medical History (Check all that apply):	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis/Liver Ds
	<input type="checkbox"/> Stroke	<input type="checkbox"/> COPD or Emphysema	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Reflux/Heartburn
	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Hypothyroidism
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Knee/Joint Pain
	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> HIV	<input type="checkbox"/> Cancer _____	
Have you ever had a colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____				
Please list any other medical conditions:				

PAST SURGICAL HISTORY	
Surgical History and type:	Date of Surgery:
<input type="checkbox"/> None	
<input type="checkbox"/> Chest Surgery	
<input type="checkbox"/> Abdominal Surgery	
<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Breast Surgery	
<input type="checkbox"/> Heart Surgery	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Weight Loss Surgery	
<input type="checkbox"/> Other	

FAMILY MEDICAL HISTORY	
Do you have any siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, How many sisters? _____ brothers? _____	
half-sisters? _____ half-brothers? _____ stepsisters? _____ stepbrothers? _____	
Your Birth Order/Position in family: _____	
Family History:	Family Relationship:
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Aneurysms	
<input type="checkbox"/> Obesity	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Sibling(s)
The information from the following question may not be included in your report to the doctor, but is important for the psychologist to know: Have you ever been physically, sexually, verbally, or emotionally abused? If yes, explain: _____	

Addiction(s) continued:	within the past:	Current? How long?	Past? What year(s)?
	Gambling _____	_____	_____
	Shopping _____	_____	_____
	Pornography/Sex _____	_____	_____
	Other _____	_____	_____
	Are there addiction problems in your immediate and/or extended family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please note which addiction(s): <input type="checkbox"/> Gambling <input type="checkbox"/> Shopping <input type="checkbox"/> Pornography/Sex <input type="checkbox"/> Other _____ Who? _____ _____		
Mental Health	Are you currently, or have you ever been in counseling with a professional therapist or a psychiatrist for a mental <i>health problem</i> (such as: Anxiety, Depression, or Family Conflict, Alcohol/Drugs, Anger,?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when, why and where? _____ _____		
	Have you ever had suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____		
	Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____		
	Have you ever felt homicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when/how recently? _____		
	Have you ever attempted to end someone else's life? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____		

REVIEW OF SYSTEMS	
Check the boxes that apply to YOU.	
Constitutional:	<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight Loss
Eyes:	<input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision
Cardiovascular:	<input type="checkbox"/> Heart attack or chest pain <input type="checkbox"/> Pain in legs with walking
ENT:	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sore throat
Respiratory:	<input type="checkbox"/> Excessive shortness of breath <input type="checkbox"/> Chronic/Persistent cough
Gastrointestinal:	<input type="checkbox"/> Recent blood in stool <input type="checkbox"/> Heart Burn
Genitourinary:	<input type="checkbox"/> Difficulty with urination <input type="checkbox"/> Incontinence
Musculoskeletal:	<input type="checkbox"/> Leg cramps <input type="checkbox"/> Joint pain
Skin/Breast:	<input type="checkbox"/> Breast mass <input type="checkbox"/> Nipple discharge
Neurological:	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Other: _____
Endocrine:	<input type="checkbox"/> Hot/Cold episodes <input type="checkbox"/> History of thyroid disease
Hematology/Lymphatic	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> History of blood clots

WEIGHT HISTORY

Please indicate your weight at the following times during your life. Note significant life events that contributed to weight gain during the given age ranges (EG: divorce, child born, abuse, death of loved ones, injuries, etc.)

Age	Weight	Significant Life Events at that Age
0 – 5		
6 – 12		
12 – 18		
20-30		
30-40		
40-50		
50-60		
60-70		

PATIENT READINESS

Readiness	<p>For how long have you been seriously trying to lose weight? _____ years</p> <p>Rate the following on a scale from 0 – 10:</p> <p style="padding-left: 20px;">Your seriousness at dieting attempts: _____</p> <p style="padding-left: 20px;">How desperately you want to lose weight: _____</p> <p style="padding-left: 20px;">Your level of frustration with medical weight loss programs: _____</p> <p>What are you willing to do to lose and maintain a significant amount of weight loss?</p> <p>_____</p> <p>_____</p> <p>Are you willing to attend individual counseling if it is recommended prior to your having weight loss surgery?</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No (If not, why? _____) Are you willing and able to attend Live Healthy Support Group meetings before and after your weight loss surgery?</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No (If not, why? _____)</p>
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Diet History

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

Your age at the time _____

What did you do to lose this weight? _____

How long did it take to lose this weight? _____

How long did it take to regain the weight? _____

And how much did you regain? _____

Which of the following have you tried at some time?

Diet	Your Age at the Time of Diet	Amount of Weight Lost	Length of time you kept weight off
<input type="checkbox"/> Adkins			
<input type="checkbox"/> South Beach			
<input type="checkbox"/> Grapefruit			
<input type="checkbox"/> Cabbage			
<input type="checkbox"/> Jenny Craig			
<input type="checkbox"/> Weight Watchers			
<input type="checkbox"/> PHC			
<input type="checkbox"/> Nutrisystem			
<input type="checkbox"/> Diet Pills			
<input type="checkbox"/> Very Low Cal Diet			
<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:			

Professional advice

Which of the following professionals have you worked with to lose weight?

Professional	Your Age at the Time of Diet	Amount of Weight Lost	Length of time you kept weight off
<input type="checkbox"/> Family Doctor			
<input type="checkbox"/> Weight Loss Specialist/ MD			
<input type="checkbox"/> Dietician			
<input type="checkbox"/> Psychologist			
<input type="checkbox"/> Overeaters Anonymous			
<input type="checkbox"/> Weight Watchers			
<input type="checkbox"/> Other			

Preparation
for surgery

What is the most important reason you are interested in weight loss surgery:

What are your weight loss goals: _____

What do you believe is a healthy weight for you? _____

How confident are you that you can/will lose the amount of weight you expect to
following surgery? Extremely Somewhat Not at all Unsure

How confident are you that you will MAINTAIN your weight loss over time?
 Extremely Somewhat Not at all Unsure

How does your family feel about you pursuing weight loss surgery?
 Supportive Skeptical Unsupportive Think you're crazy

What have you done to research the option of weight loss surgery?
 Internet Research Informational Session Books Other Patients
 Other Sources: _____

What weight loss operation are you considering?
 Gastric Bypass Gastric Banding Sleeve Gastrectomy
 Duodenal Switch Not Sure

What side effects are you aware of in terms of bariatric surgery? _____

Will anyone attempt to sabotage your weight loss? _____ Who? _____

To what extent do you enjoy physical activity?
 Not at all Slightly Moderately Greatly

Do you currently exercise? Yes No
If so, what do you do and how often? _____

Are you aware of the guidelines for how much time is suggested for exercise in order to
keep weight off after losing weight? No, I'm not aware.
 Yes, they are: _____

Preparation
for surgery
continued:

How do you SPECIFICALLY plan to meet the exercise requirements?

What SPECIFIC healthy eating and exercise behaviors are you willing to implement between now and the time you have the surgery AND that you will continue following your surgery in order to lose weight and maintain the weight loss?

What positive coping skills do you use on a regular basis to help you get through difficult situations? (A positive coping skill is a behavioral tool which may be used to help in difficult situations, such as deep breathing, journaling, etc.) If none then state none.

How do you think that stress in your life affects your eating – in terms of food selections, eating habits (such as eating too quickly, eating while watching TV, etc.)?

Given that weight loss surgery does NOTHING to change your thinking patterns, does NOTHING to prevent you from going fast food restaurants or from going to a buffet, does NOTHING to keep holidays from coming and people serving wonderful “bad” foods, does NOTHING to change your old eating habits (times you eat, eating in front of the TV, snacking at work, etc.) what makes you think you will be successful LONG TERM in keeping your weight off because you are having surgery?

Eating Attitudes Test (EAT – 26)

For each of the statements below, please choose one of the following six responses:

Always = 3 Usually = 2 Often = 1 Sometimes = 0 Rarely = 0 Never = 0

Questions	Score
1. I am terrified about being overweight.	_____
2. I avoid eating when I am hungry.	_____
3. I find myself preoccupied with food.	_____
4. I have gone on eating binges where I feel that I may not be able to stop.	_____
5. I cut my food into small pieces.	_____
6. I am aware of the calorie content of foods that I eat.	_____
7. I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.).	_____
8. I feel that others would prefer if I ate more.	_____
9. I vomit after I have eaten.	_____
10. I feel extremely guilty after eating.	_____
11. I am preoccupied with a desire to be thinner.	_____
12. I think about burning up calories when I exercise.	_____
13. Other people think that I am too thin.	_____
14. I am preoccupied with the thought of having fat on my body.	_____
15. I take longer than others to eat my meals.	_____
16. I avoid foods with sugar in them.	_____
17. I eat diet foods.	_____
18. I feel that food controls my life.	_____
19. I display self-control around food.	_____
20. I feel that others pressure me to eat.	_____
21. I give too much time and thought to food.	_____
22. I feel uncomfortable after eating sweets.	_____
23. I engage in dieting behavior.	_____
24. I like my stomach to be empty.	_____
25. I have the impulse to vomit after meals.	_____
26. I enjoy trying new rich foods.	_____
TOTAL SCORE	_____

NUTRITION ASSESSMENT

Allergies	List any food allergies or intolerances.			
	<u>Food</u>	<u>Allergy/Intolerance Symptoms</u>		
	_____	_____		
	_____	_____		
	_____	_____		
Food choices	Please answer each question with a number.			
	How many times per week do you eat fast food? _____			
	How many times per week do you dine out? _____			
	How many times per week do you eat fried foods? _____			
	How many times per week do you eat sweets? _____			
	How many times per week do you drink alcohol? _____			
Beverages	Check the beverages you drink and how much/how often:			
	Beverage	Serving size (ounces)	Servings per week	
	<input type="checkbox"/> Soda			
	<input type="checkbox"/> Diet Soda			
	<input type="checkbox"/> Juice			
	<input type="checkbox"/> Milk			
	<input type="checkbox"/> Tea			
	<input type="checkbox"/> Sweet Tea			
	<input type="checkbox"/> Coffee			
	<input type="checkbox"/> Cream <input type="checkbox"/> Sugar			
	<input type="checkbox"/> Fruit Drinks			
	<input type="checkbox"/> Water			
	<input type="checkbox"/> Beer			
	<input type="checkbox"/> Wine			
	<input type="checkbox"/> Liquor			
	<input type="checkbox"/> Other			
Check the foods you crave the most (if any):	<input type="checkbox"/> Pasta	<input type="checkbox"/> Rice	<input type="checkbox"/> Potatoes	<input type="checkbox"/> Bread
	<input type="checkbox"/> Cereal	<input type="checkbox"/> Sweets	<input type="checkbox"/> Chips	
Check the protein rich foods you enjoy most:	<input type="checkbox"/> Beef	<input type="checkbox"/> Chicken	<input type="checkbox"/> Turkey	<input type="checkbox"/> Fish
	<input type="checkbox"/> Eggs	<input type="checkbox"/> Tofu	<input type="checkbox"/> Wild Game	<input type="checkbox"/> Nuts
Do you eat at least one of these foods every day? _____				
Do you eat breakfast every day? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, what do you eat? _____				
Do you regularly skip meals? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If so, what meal do you skip? _____				
What do you perceive as your biggest weakness in your diet? (check all that apply)	<input type="checkbox"/> Portion Control	<input type="checkbox"/> Light Night Eating	<input type="checkbox"/> Emotional Eating	
	<input type="checkbox"/> Grazing	<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Meal Skipping	
	<input type="checkbox"/> Sweets	<input type="checkbox"/> Sugared Beverages	<input type="checkbox"/> Other: _____	

3-Day Food Diary

Please use this form to keep a record of everything you eat and drink for the last 3 days or a typical 3 days. Please write everything you eat and drink down and approximate amounts. This will help me determine what changes you need to make after your surgery. Please be honest. This will in no way determine whether or not you are a good candidate for weight loss surgery. **MUST BE COMPLETED**

Day 1	Day 2	Day 3
<u>Breakfast</u>	<u>Breakfast</u>	<u>Breakfast</u>
<u>Lunch</u>	<u>Lunch</u>	<u>Lunch</u>
<u>Dinner</u>	<u>Dinner</u>	<u>Dinner</u>
<u>Snacks</u>	<u>Snacks</u>	<u>Snacks</u>

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS
General and Bariatric Surgery /Medical Weight Loss
(here after referred to as Live Healthy MD)

PATIENT ACKNOWLEDGMENT FORM

Patient's Name: _____ SSN: _____ DOB: _____

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

I understand that Live Healthy MD may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that the nutritionist(s) and mental health practitioner(s) who contract with Live Healthy MD and the program director will have access to my medical file. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

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

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

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

I have received a copy of Live Healthy MD "Notice of Privacy Practices".

Signature: _____ Date: _____

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

PATIENT ACKNOWLEDGMENT FORM CONTINUED

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

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

The above information on all of these pages has been completed by me and is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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

Printed name of Patient and/or Personal Representative: _____

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS

General and Bariatric Surgery /Medical Weight Loss

Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of service your appointment may be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account to include deductibles. We appreciate payment in full by the billing due date. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through the use of:
 - a. Recurring payment with a credit/debit card
 - b. Establishing monthly payment contract with our office
 - c. Extension of a line of credit through a medical services credit company
3. Statements will be mailed to you monthly for our outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia. Monthly finance charges may be applied to all outstanding balances over 30 days.
4. Prior to elective surgery we will confirm benefits, and calculate balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We expect payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing concerns after the rendered services.
5. Questions or concerns regarding your bills should be addressed directly with the midtown billing staff and not your physician at (706) 738-3359.
6. We take pride in our relationship with you and appreciate you giving us the unique opportunity to care for you and your family. We understand that medical care can be costly. We are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter. We cannot help you if we do not know what the problem is regarding making payment.
7. I give my permission for the staff and physicians at Midtown Surgical and Live Healthy MD to contact me with automated reminders by the above methods. I understand that patient specific medical information will not be left, but information about appointment dates, times, doctors and locations and instructions will be communicated. We cannot guarantee that someone else other than the intended patient will not receive the call/message.

PRINTED NAME

SIGNATURE

DATE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____ SSN: _____

I authorize:

To release healthcare information of the patient named above to:

**Dr. Michael Blaney /Dr. Francisco Jacome /Dr. Dennis H. Jones/
Dr. Edward Boland/Dr. Mary Lu Thompson
Midtown Surgical Specialists
Live Healthy MD
3830 Washington Rd Suite 17
Martinez, GA 30907
Phone: 706-922-0440 Fax: 706-922-0441**

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition or dates:

- All healthcare information
- Other:

Yes No I authorize the release of my SID results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the persons(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone..

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date:** _____

LIVE HEALTHY MD/MIDTOWN SURGICAL SPECIALISTS
General and Bariatric Surgery /Medical Weight Loss

Automated Message Consent

In our office we have an automated system that will allow us to communicate with you better. The system will allow us to send you automated appointment reminders and other messages by:

1. voice message (land and cell lines): **Home #** _____

Cell # _____

Work # _____

2. text message (must have text capability) **Cell #:** _____

3. email address: _____

4.

1. Can we contact you by this system (we will not leave medically sensitive information):

YES No

2. If YES, then please answer the following questions:

1. How do you want to be contacted:

Voice Text Both

2. If voice message, then what number do you prefer us to call:

Home Cell Work

3. When do you want to get these messages

Morning Afternoon Evening

Signature: _____ Date: _____