



Dear Applicant:

We are delighted you have chosen the Obesity Solutions Bariatric Program for your weight loss surgery. Our skilled and experienced surgeons combined with our dedicated Bariatric Team have designed a comprehensive program with proven success.

Enclosed in this packet are the application materials you need to get started with the screening process for our program. This information is vital to maximize the opportunity for success in our program.

Please complete the application, answering all of the questions fully and honestly. We also recommend that you keep a photocopy of the completed application for your personal records. Return the entire packet to Obesity Solutions in the envelope provided.

Application Directions

1. Please print with blue or black ink.
2. Include an enlarged front & back copy of your insurance card(s). Please provide copies of ALL health insurance cards, even if that insurance does not cover weight loss surgery.
3. Include a copy of your driver's license/identification card.
4. Complete every page of the application.
5. Every item on the application should be answered with a "yes", "no", or "n/a" for not applicable, do not leave anything blank.
6. Explain all "yes" answers.
7. Provide your primary care physician's first & last name, address, phone number and fax number.

Please allow sufficient time for postal delivery and initial processing of the application once it has been received by our staff.

If you have any questions regarding how to complete your application, please contact our office at 770-534-0110.

We know you are looking forward to your new life and we are proud to be part of this endeavor.

Thank you,

Robert L. Richard, MD, FACS
And the staff of Obesity Solutions



Name: _____ Date: _____

Bariatric Program Application

PART I. PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

Patient's Name _____

Preferred name to be called _____

Social Security # _____ Date of Birth _____

Mailing Address _____
(Street) (Apt #) (City) (State) (Zip Code)

Street Address _____
(Street) (Apt #) (City) (State) (Zip Code)

Home Phone _____ Cell Phone/Pager _____

Work Phone _____ May we call you at work? _____

What is the best way to reach you during the day? _____

Gender: Female Male Race/Ethnicity _____

Marital Status: Single Married Divorced Widowed

Employer's Name & Address _____

Occupation _____

Spouse/Partner's Name _____ Day Time Phone # _____

Emergency Name and Phone Number (other than spouse/partner)

Name _____ Relationship _____

Phone # _____

Person Responsible for Payment (if other than patient)

Name _____ Relationship to Patient _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone/Pager _____ Soc Sec # _____



Name: _____ Date: _____

PART I. PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

Insurance Information

- 1) *Please provide us with a front & back copy of all of your insurance cards.*
- 2) *Omitting a front & back copy of all your insurance cards will delay the processing of your application.*
- 3) *Even if you have given us a copy of your insurance card, please complete the starred "*" lines below.*
- 4) *If you have more than one insurance policy, please indicate which is primary and which is secondary.*

Primary Insurance Coverage

*Insurance Company Name _____

*Patient's Policy # or ID # _____ Group # and Name _____

Insurance Company Address _____

Insurance Company Phone Number _____

*Name of Person who subscribes to insurance _____

*Subscriber's Relationship to Patient _____

*Subscriber's Date of Birth _____ *Subscriber's Soc Sec # _____

*Subscriber's Employer _____

Secondary Insurance Coverage

*Name of Secondary Insurance _____

*Patient's Policy # or ID # _____ Group # and Name _____

Insurance Company Address _____

Insurance Company Phone Number _____

*Name of Person who subscribes to insurance _____

*Subscriber's Relationship to Patient _____

*Subscriber's Date of Birth _____ *Subscriber's Soc Sec # _____

*Subscriber's Employer _____

***Please write the name and relationship of the person completing these forms, if not completed by the patient ***

Name _____ Relationship _____



Name: _____ Date: _____

PART I. PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

Referral Source

Please list the name, address, phone and fax numbers of the **physician who referred** you to our program.

Please list the name, address, phone and fax numbers of your primary care doctor, if different from the physician who referred you to our program.

If a physician did not refer you to our program, then how did you **first** hear about us? Circle one:

- | | | | | |
|-----------|--------------------|-----------------|------------|--------------------------|
| Friend | Family Member | Doctor's Office | Google/web | Obesity Solution Website |
| Newspaper | Longstreet Website | Radio | TV | Billboard |

AUTHORIZATIONS & RELEASES

- I verify that all of the information contained within these forms is valid and accurate.
- I understand that the Obesity Solutions Bariatric Program uses a holistic, multi-disciplinary approach to patient screening, education, treatment and care.
- I understand any personal, demographic, insurance, medical, psychiatric and other information that I provide to a Bariatric Program team member office & its staff may be shared with all treatment providers to allow for the maximum opportunity for success.
- The Bariatric Program team members include, but are not limited to, the employees of Center for Bariatric Surgery at The Longstreet Clinic, PC (dba) Obesity Solutions, Northeast Georgia Health Systems and their affiliates, and Obesity Solutions' preferred psychological providers.
- *I authorize the Bariatric team members to release any information and medical records to my insurance provider and third party payer and/or its agents, so that payment for services rendered may be obtained for this or a related claim or as part of the authorization or pre-certification process.*
- I authorize my insurance provider to pay all medical benefits directly to the billing Bariatric team member, including those benefits otherwise payable to me.
- I understand that the billing and collection policies of the Bariatric team members may vary and that I will be informed of these policies as I come in contact with each member office.

I have read the Authorizations and Releases. I understand and agree to the above stated policies.

Patient's Signature

Date



Name: _____ Date: _____

TYPE OF SURGERY

Obesity Solutions is honored to be able to offer their patients choices. Our surgeons want you to be comfortable in the decision you have made to have weight loss surgery. Obesity Solutions feels that pre operative education is a key component to your weight loss success no matter which procedure you choose to have. In order to complete that education, we provide online education for Gastric Bypass, Sleeve Gastrectomy and Laparoscopic Adjustable Gastric Banding Surgery.

Please indicate which type(s) of surgery you would like to be considered for?
(Check all that apply.)

_____ Roux-en Y Gastric Bypass

_____ Laparoscopic Adjustable Gastric Band (LAGB) (Lap-Band® or Realize Band®)

_____ Sleeve Gastrectomy

_____ Revision of a previous gastric surgery

_____ Undecided



Name: _____ Date: _____

CONTACT FORM

Throughout the program, it is important that we keep open communication with you. Therefore, we ask you to give us the best contact information below.

Primary Contact number: _____ Home Work Mobile

Email Address: _____

Please list the best time to call you. Please be as specific as possible.

Day of the Week: _____

Morning: _____

Afternoon: _____

If you work or have regularly scheduled commitments, please list those dates and times.

May we leave a message for you?

At home? _____

At work? _____

On your cell phone? _____

May we speak with anyone other than yourself regarding your medical conditions, appointments, application status, insurance status or any other items relating to your application to our program? **Please note that we will always contact you first, unless you indicate otherwise.**

If yes, please list that person's name, their relationship to you and how we may reach this person.

Name: _____ Relationship: _____

Phone #: _____ Alternative phone #: _____

Signature: _____ Date: _____



Name: _____ Date: _____

PART II. MEDICAL HISTORY

HEIGHT & WEIGHT

Please list your current age, height, weight and estimated BMI.

Age _____ Current Height _____ Current Weight _____ BMI _____

SOCIAL HISTORY

Highest level of schooling completed? _____ Religious Preference: _____

Smoking History: (Please circle one)

___ **Current Smoker** How many packs per day? _____

___ **Former Smoker** Year Quit: _____

___ **Never Smoked**

___ **Smokeless tobacco products** How often: _____

Do you drink alcohol? _____ How often _____ **Illegal Drug Use?** _____ How often? _____

Do you exercise? _____ How often & what type? _____

Do you have a strong support system? _____

Who is your support person(s)? _____

Have you had any prior gastric bypass/weight loss surgery? (If yes, please give the type of procedure, date of surgery, name, address and phone number of the surgeon and the facility where the surgery was performed.)

Have you ever taken Phen/Fen? _____ Have you ever taken Redux? _____



Name: _____ Date: _____

PART II. MEDICAL HISTORY

TREATING PHYSICIANS (Please list all doctors you are currently seeing.)

Name	Address/Phone Number	Reason

MEDICATIONS (List all current *prescription & over-the-counter* medications you use.)

Medication Name	Amount/Dosage	How Often?	Reason/Prescribing M.D.

Do you use birth control pills? _____ Do you use estrogens? _____

VITAMINS & SUPPLEMENTS (List any *vitamins, supplements or herbal remedies* you are currently using.)

Name	Amount/Dosage	How Often?	Reason

ALLERGIES (Please list any allergies you have, including *foods, medications, metals or other substances*.)

Type of Allergy	Reaction

SURGICAL HISTORY Please list any previous surgeries you have had.

Surgery	Reason	Dates	Complications



Name: _____ Date: _____

PART II. MEDICAL HISTORY

PHYSICAL LIMITATIONS/DISABILITIES (Please check all that apply).

- Airline Travel
- Caring for Personal Needs
- Climbing Stairs
- Lifting Objections from Floor
- Other (please explain) _____
- Playing with Children
- Tying Shoelaces
- Unusual Fatigue
- Use of Public Seating

PERSONAL MEDICAL HISTORY

- Have you had or do you have any of the following illnesses or symptoms?
- Please mark **EVERY** blank with "YES" or "NO."
- For every "YES" answer, please indicate the treatment(s) you have tried including prescriptions and over-the-counter medications, medical or non-medical treatment and surgeries. Please provide as much detail as possible including severity of the illness/symptoms, dates of treatment and whether or not the treatment provided relief.

BONES/JOINTS

Arthritis/Osteoarthritis _____ Low Back Pain/Sciatica _____
 Pain in Ankles _____ Pain in Feet _____ Pain in Knee _____ Pain in Hips _____
 Other _____

CANCER

Cancer _____ Type _____ Treatment _____

ENDOCRINE

Diabetes _____ Insulin Dependent _____ Non-Insulin Dependent _____ Gestational/Pregnancy _____
 Neuropathy (Numbness of Hands and/or Feet) _____
 Thyroid Disease (Hyper) _____ (Hypo) _____
 Other _____

GI

Belching Acid _____ Heartburn _____ Reflux _____ Peptic Ulcer _____
 Colitis (Inflammation of the lining of the Stomach) _____
 Gallbladder disease (Removed?) _____ Hiatal Hernia _____
 Hepatitis (Type) _____
 Bowel problems _____ IBS _____ Constipation _____ Diarrhea _____

HEART

Abnormal EKG _____ Angina (Chest Pain) _____ Cardiac Arrest (Heart Attack) _____
 Cardiac Bypass _____ Congestive Heart Failure _____ Heart Disease _____ Heart Murmur _____
 High Blood Pressure/Hypertension _____ High Cholesterol/Hypercholesterolemia _____ High Triglycerides _____
 Other _____



Name: _____ Date: _____

PART II. MEDICAL HISTORY

KIDNEY/RENAL

Kidney/Renal Disease _____ Kidney Stones _____

Other _____

MENTAL HEALTH

Alcohol Abuse _____ Anxiety Disorder _____ Depression _____

Illegal Drug Abuse _____ Past Suicide Attempts _____ Other _____

Previous Mental Health Counseling _____

OB/GYN

Infertility _____ Hysterectomy _____ Menstrual Irregularity _____

Number of Pregnancies _____ Number of Live Births _____ Type of Delivery _____

Is it possible you are currently pregnant? _____

Other _____

RESPIRATORY

Asthma _____ Bronchitis _____ COPD _____ Emphysema _____

Frequent Respiratory Infections _____ Shortness of Breath _____ TB/Tuberculosis _____

Have you ever been diagnosed with Obesity-Hypoventilation Syndrome _____

Other _____

SKIN

Infections/Rashes/Ulcers _____

Other _____

SLEEP

Coughing/Choking at Night _____ Excessive Snoring _____ Narcolepsy _____ Nighttime Reflux _____ Sleep

Apnea _____ Have you had a sleep study? _____ Do you use CPAP/BiPAP? _____

Please list when and where the study was performed? _____

Other _____

UROLOGY

Frequent Urinary Tract Infections _____ Leakage of Urine _____

Other _____

VASCULAR/BLEEDING

Abnormal Bleeding _____ Blood Clots/DVT _____ Venous Stasis Disease _____

Other _____



Name: _____ Date: _____

PART II. MEDICAL HISTORY

CHILDHOOD ILLNESS & OPERATIONS Please list any childhood diseases, illnesses and/or surgeries.

OTHER MEDICAL INFORMATION Please list any other medical information not listed above, including illnesses, conditions, surgeries and hospitalizations.

Have you ever had a blood transfusion? (If yes, give date and reason.) _____

Do you have religious objection to the use of blood products? _____

Do you have any person or family history of abnormal bleeding? (If yes, please explain, include details and dates.) _____

FAMILY HISTORY

Medical/Psychiatric Conditions should include any suicide attempts, mental illnesses, and any alcohol drug or other types abuse.

	Age	Ht	Wt	Medical/Psychiatric Condition	<u>Check if Family Member is Deceased</u>
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
<i>Your Mother's Side of the Family</i>					
Grandmother	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____
Aunt	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Uncle	_____	_____	_____	_____	_____
<i>Your Father's Side of the Family</i>					
Grandmother	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____
Aunt	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Uncle	_____	_____	_____	_____	_____



Bariatric Food and Nutrition History

Obesity Solutions 1250 Jesse Jewell Parkway, Suite 300
Gainesville, GA 30501 Phone 770-534-0110 Toll Free 877-921-0110

Patient Name _____ Age: _____ Male or Female _____ Date _____

Height: _____ Current weight: _____ Goal wt: _____ Wt in high school: _____

Estimate how many calories you are consuming daily: _____

In the past 6 months, have you had any *unintentional* weight loss or weight gain? No Yes: _____ lbs.

Please be as specific as possible when completing this history as this information may be requested, and forwarded to your insurance company for the approval process.

GENERAL QUESTIONS

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/what age? _____

Have you ever had counseling with a registered dietitian or nutritionist? No Yes Who? _____

Have you ever had any weight loss procedures before? No Yes

If yes, please provide the date and type of operation: _____

What was your single greatest weight loss? _____ lbs. How long did it take to regain the weight? _____

How was this weight loss obtained? (Be specific, i.e. Weight Watchers, Diet Pills, etc.)

How long did you sustain that weight loss? _____

How many times have you lost over 25 pounds? _____

✓ Are you currently under a physician's care for weight loss? Yes No

✓ Physician Name: _____

✓ Address and phone number: _____

Do you have any food allergies, intolerances or avoidances? No Yes: _____

Do you take vitamins/minerals/ herbal supplements Yes No If yes, what kind? _____

Please submit documentation where applicable that supports diet attempts. Please check and provide specific information for all diets that apply.

Medically Supervised Diet Programs	Number of Attempts	When (dates)	Length of Time	Weight Loss	Weight Regained	MD/City
Medi-fast						
Opti-fast						
Fen/Phen						
Redux						
Meridia						
Xenical						
Behavior Mod. PSY Therapy						
Hypnosis						
Acupuncture						
The Center for Medical Wt loss						
Prozac?						
Synthroid?						
Diabetic Diet						
Other						
Non-MD Supervised	Number of Attempts	When (dates)	Length of Time	Weight Lost	Weight Regained	MD/City
Weight Watchers						
Nutri-Systems						
Jenny Craig						
TOPS						
Over Eaters Anonymous						
Sugar Busters						
Liquid Diets						
Sego						
Slim Fast						
Metracal						
Sweet Success						
Liquid Protein						
DASH						
Miscellaneous Diets	Number of Attempts	When (dates)	Length of Time	Weight Lost	Weight Regained	MD/City
Low Calorie						
Low Fat						
High Protein						
Self Imposed Fasts						
Dr. Atkins						
Scarsdale						
Pritikin						
Richard Simmons						
Susan Powter						
Herbal Life						
Cambridge						
Metabolite						
Mayo Clinic Diet						
Zone Diet						
Cabbage Soup						
Other						
Diet Pills						
Accutrim/Dexatrim						
Diurex						
Other						

NUTRITION RELATED BEHAVIORS

Who does the cooking at home? _____ Who does the shopping? _____
 How often do you eat out (away from home) ? _____ 1-2 times per week _____ 3-4 times per week _____ over
 4 times per week

Do you snack between meals?	Yes	No	Do you eat convenience/packaged foods?	Yes	No
Do you eat large meals?	Yes	No	How often do you eat each day? _____	times.	
Do you eat a lot of sweets?	Yes	No	Do you eat at night?	Yes	No
Do you drink a lot of soda?	Yes	No	Sodas (Diet or Regular)? _____	How many per day?	

Do you drink alcohol?	Yes	No	Which kind? beer/wine/liquor	How often? _____
Do you like fruits and vegetables?	Yes	No	Do you drink milk? _____	How often? _____ Skim /2%/
Whole				
How often do you eat meat? _____	Do you use fat? _____		What kind? _____	

Are you an emotional eater? What causes you to eat? _____

Have you ever forced yourself to vomit after eating? (binge and purge) Yes No

Do you currently force yourself to vomit after eating? Yes No

Have you always been overweight? Yes No

Usually I eat with someone? Yes No I eat when I am not hungry? Yes No

What would you consider your pace of eating? slow normal fast

Explain why you feel you can be successful with weight loss after this surgery, despite the extreme lifestyle and dietary changes needed: _____

List one eating behavior you would like to change right now? _____

ACTIVITY / EXERCISE:

In regards to daily activity, would you consider yourself: very active somewhat active not very active

Number of hours/day watching TV: _____ Number of hours/day on computer: _____

To what extent do you enjoy activity/exercise? (*circle one*) Not at all Slightly Moderately Greatly

Where do you exercise: Health Club YMCA Home Outdoors Pool Walking Jogging

Are you active in any organized activities: _____ No Yes: _____

Aerobic Training (group class, walking, swimming etc): Yes No Resistance Training (Weight lifting) : Yes No

How many days per week? _____ How long do you exercise each day? _____

Have you participated in Activity/Exercise in the past: _____ No Yes _____ What Kind _____

What kinds of exercise do you like: _____

Is there a physician who can document your diet/weight loss attempts for at least 6 months? Yes No

Physician name and contact information: _____

Please list other questions or concerns you have regarding nutrition and exercise: _____



Name: _____ Date: _____

Epworth Sleep Scale

Sleep problems are a serious threat to your health, safety and well-being. The Epworth Scale is a quick and simple test designed to detect if you may have a sleep disorder. Please answer the following questions and total your score to see if you may have a sleep problem.

How likely are you to doze 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 some of these things recently, 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 of dozing
- 2 = MODERATE chance of dozing
- 3 = HIGH chance of dozing

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (theater, meeting, etc.) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking with someone _____

Sitting quietly after lunch without alcohol _____

In a car, while stopping for a few minutes in traffic _____

TOTAL _____

If you scored eight (8) or more points, you should make an appointment with your doctor to discuss the results or call the Sleep Disorders Center for more information at **(770) 219-6263**.



Name: _____ Date: _____

DATE: _____

**The Sleep Disorders Center of
Northeast Georgia Medical Center**

MAP Score: _____

**Multivariable Apnea Risk Index (MAP)
Sleep Symptom-Frequency Questionnaire Worksheet**

During the last month, on how many nights or days per week have you had or been told you had the following (please check only one box per questions):

	(0) Never	(1) Rarely (less than once a week)	(2) Sometimes (1-2 times Per week)	(3) Frequently (3-4 times Per week)	(4) Always (5-7 times Per week)	(.) Do Not know
Account Number:						
Attending MD:						
Gender:						
1. Loud Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your legs feel jumpy or jerky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Frequent awakenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Snorting or gasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Falling asleep when at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Frequent tossing, turning, or thrashing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Your breathing stops or you choke or struggle for breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Excessive sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Falling asleep while driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Feeling paralyzed, unable to move for short periods when falling asleep or awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Find yourself in a vivid dreamlike state when falling asleep or awakening even though you know you are awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Any snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pt Name: _____ Room: _____ DOB: _____ Ht: _____ Age: _____

Wt: _____ BMI: _____ PCP: _____ Tech Name: _____ MIC: _____