

**Please complete the following questionnaire and bring it with you to your appointments.
 If you are unsure about how to answer a question, make an educated guess or leave it blank.**

PATIENT INFORMATION			
Patient Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Birthdate:	Soc. Sec. no.:	Marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
Mailing address:		Apt no.:	
City:	State:	Zip:	
Home Phone no.:		Cell Phone no.:	
Email Address:			
Referring Physician's Name:			
Referring Physician Address and Phone Number:			
Reason for this Visit:		Initial Date of Service:	
Height: _____ ft. _____ in.	Weight: _____ lbs.		
EMPLOYER INFORMATION: <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student			
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Retirement date:	
Employer/School name:			
Patient occupation:		Work phone no:	
Employer address:			
City:	State:	Zip:	
POLICY HOLDER INFORMATION: <input type="checkbox"/> Patient (Self)			
Policy Holder Name:		Relationship to patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	
Date of birth:	Phone:	Social Security no.:	
Address:			
City:	State:	Zip:	
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired		Retirement date:	
Employer/School Name:			
Occupation:		Work phone:	
Employer address:			
City:	State:	Zip:	
NEAREST RELATIVE(S)			
Name:		Relationship to patient:	
Home phone no:		Work phone no:	
Name:		Relationship to patient:	
Home phone no:		Work phone no:	

PRIMARY INSURANCE INFORMATION			
Carrier/Plan:		Phone no:	
Address:			
City:		State:	Zip:
Policy no.:		Group no.:	
Name of insured:		Insured's birth date:	
Insured's mailing address:			
City:		State:	Zip:
Insured's Soc. Security no.:		Patient's relationship to insured:	
Insured's employment status:		Insured's employer:	
Employer's address:		Work phone no.:	
City:		State:	Zip:
Claim no.:	Comments:		
SECONDARY INSURANCE INFORMATION			
Carrier/Plan:		Phone no:	
Address:			
City:		State:	Zip:
Policy no.:		Group no.:	
Name of insured:		Insured's birth date:	
Insured's mailing address:			
City:		State:	Zip:
Insured's Soc. Security no.:		Patient's relationship to insured:	
Insured's employment status:		Insured's employer:	
Employer's address:		Work phone no.:	
City:		State:	Zip:
Claim no.:	Comments:		
INSURANCE AUTHORIZATION			
<p>I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S). I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ADVANCED LAPAROSCOPIC SURGEONS OF MORRIS (A.L.S.O.M.) AND/OR TO THE PHYSICIAN(S) WHO RENDERED SERVICES AT THE OFFICE.</p> <p>I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY ADVANCED LAPAROSCOPIC SURGEONS AND/OR TO THE PHYSICIAN(S) WHO RENDERED SERVICE(S), I AGREE TO BE RESPONSIBLE FOR PAYMENT.</p> <p>I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE SUCH AS, BUT NOT LIMITED TO, DEDUCTIBLE AND CO-INSURANCE AMOUNT(S). I FURTHER UNDERSTAND THAT A.L.S.O.M. CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF MY CLAIM(S) OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE LIMITS OF YOUR CREDIT POLICY.</p>			
SIGNATURE:		Date:	
<i>(Signature of person responsible for payment)</i>			

PAST MEDICAL/SURGICAL HISTORY			
Confidential Record: Information herein will be released to your insurance company for authorization for surgery. This form will be submitted to your insurance company with the Letter of Medical Necessity.			
Name:		Date:	
Date of Birth:	Age:	Height:	Weight:
BMI:		(Staff will complete BMI)	
Previous Surgeries / Procedures:			
1.			Date:
2.			Date:
3.			Date:
4.			Date:
5.			Date:
6.			Date:
Medical Conditions: (Describe illnesses not requiring hospitalization. Please list any health condition(s) for which you are currently being treated (i.e., diabetes, sleep apnea, high blood pressure, etc.)			
1.			Date:
2.			Date:
3.			Date:
4.			Date:
5.			Date:
6.			Date:
Hospitalizations: (List diseases which have required hospitalization)			
1.			Date:
2.			Date:
3.			Date:
Allergies (Drugs, latex, environmental, other)		Reaction:	
Substance:		Reaction:	
Substance:		Reaction:	
Substance:		Reaction:	
Substance:		Reaction:	
Substance:		Reaction:	
Current Medications: (List daily medications as well as those used as needed)			
Medication:	Dosage:	How often?	Condition:

Current Medications: (Continued)			

Vitamins and Supplements (Please list current vitamins and supplements)		
Type:	Amount:	How often:

Physicians: (Please provide a list of your current physicians)			
Name:	Phone:	Fax:	Address:
Primary Care / Family Doctor:			
Gynecologist:			
Pulmonologist:			
Gastroenterologist:			
Orthopedist:			
Neurologist:			
Cardiologist:			
Endocrinologist:			
Psychiatrist:			

Social History:	
Occupation:	Spouse's Occupation:
Number of children:	
General health of children:	

Personal Habits:	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?
How long?	When did you quit?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?
Do you use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	What kind/How often?
Have you ever used drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History:				
Relationship:	Age:	Health:	If deceased, cause:	Weight:
Father:		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
Mother:		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Spouse		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Thin <input type="checkbox"/> Average <input type="checkbox"/> Overweight

Do you know of any blood relative who has or had: (Check and give relationship)					
Stroke	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Problems with anesthesia	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Overweight (20 - 99 lbs.)	<input type="checkbox"/>
Obese (over 100 lbs.)	<input type="checkbox"/>	Other (Explain) <input type="checkbox"/>			

Review of Systems: Neurologic			
Do you have:			
Double vision?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weakness in arms/legs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ringing in ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Visual disturbances?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Severe headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do headaches awaken you at night?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain on one side of head?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had a convulsion?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever fainted?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What relieves headaches?	

Review of Systems: Cardiorespiratory			
<i>Have you had shortness of breath:</i>			
Doing normal work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Climbing flights of stairs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does it awaken you at night?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Accompanied by wheezing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a chronic cough?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you cough up sputum?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you need more than one pillow to sleep?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have phlebitis or inflamed leg veins?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have swollen ankles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have varicose veins?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have bleeding problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have palpitations?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>Have you ever had chest pain or tightness:</i>			
When exerting yourself?	Yes <input type="checkbox"/> No <input type="checkbox"/>	When excited or upset?	Yes <input type="checkbox"/> No <input type="checkbox"/>
After a heavy meal?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does the chest pain:			
Radiate to the arm, neck or back?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Occur only at rest?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Abate when you rest?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Review of Systems: Psychiatric			
Do you have a history of psychiatric illness? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Anxiety?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Suicide attempts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Obsessive-compulsive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bi-polar or manic depression?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Hospitalizations?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Review of Systems: Gastrointestinal			
Do you have reflux or GERD? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>Have you had pain in the stomach which:</i>			
Occurs 1 or 2 hours after meals?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is brought on by eating fried or greasy foods?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Awakens you at night?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is relieved by eating?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is relieved by antacid medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Occurs while eating or immediately after?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is relieved by bowel movement?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
<i>Do you have:</i>			
Abdominal cramps?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alternating diarrhea and constipation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain during or after bowel movements?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mucous in the stool?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Black stools?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Review of Systems: Genitourinary			
<i>Have you had:</i>			
Burning when urinating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of bladder control?	Yes <input type="checkbox"/> No <input type="checkbox"/>

WEIGHT MANAGEMENT HISTORY

This form is submitted to your insurance company with your Letters of Medical Necessity from the physicians. Approval or denial of your request for surgery depends on meeting the criteria set forth by your insurance company. The failure of multiple, attempted dietary programs is a standard requirement. Please be as thorough and complete as possible.

Years you have been morbidly obese:

	Normal	Obese	Over 100 lbs. (morbidly obese)
Childhood (1 — 10 years)			
Adolescence (11 — 18 years)			
Young adult (18 — 30 years)			
Adult (30 — 60 years)			
Weight for last three years: 2006 _____ 2007 _____ 2008 _____ 2009 _____ 2010 _____			
Average amount of weight gained yearly:			lbs/ year:
Women—Weight retained after each pregnancy:	lbs./ year:	lbs./ year:	lbs./ year:

Medically Supervised Weight Loss Programs:

Doctors who have treated you for obesity:	Recommended Programs	Weight Lost	Weight Regained	Length of Program	Est. Cost
	Optifast				
	Medifast				
	Xenical				
	Phen-Fen				
	Meridia				
	Pondimin				
	Diabetes education				
	Previous Weight Loss surgery				

Other programs that you have attended for 6 months or more:

Program	Year	Weight Lost	Weight Regained	Number of Months	Length of Program	Est. Cost
Weight Watchers						
Overeaters Anonymous						
Diet Centers						
NutriSystem						
Jenny Craig						
Medications (non prescription)						

Programs (Continued)						
Susan Powder						
Richard Simmons						
Slim Fast						
HMR						
Non-medically supervised i.e., Atkins						
The South Beach Diet						
Other						

Physical Exercise:					
Program	Time spent	Wt. lost	Wt. regained	Length of program	Est. cost
Bicycle					
Jogging					
Walking					
Swimming					
Spa membership					
Aerobics					
VHS tapes/DVD					
Home gym equipment					
Personal trainer					
Other					

PROTECTED HEALTH INFORMATION:	
<p>I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (THE NOTICE). THIS NOTICE PROVIDES A COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PERSONAL PROTECTED HEALTH INFORMATION (PHI). I HAVE HAD AN OPPORTUNITY TO REVIEW THIS INFORMATION BEFORE SIGNING THIS FORM. I GRANT MY CONSENT TO THE HOSPITAL AND/OR ANY PHYSICIAN(S) PARTICIPATING IN MY CARE, RELEASING MY PHI (EITHER IN WRITING OR VERBALLY) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. THIS INCLUDES ANY MEDICAL INFORMATION (INCLUDING DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION, PSYCHIATRIC TREATMENT INFORMATION AND HIV-RELATED INFORMATION, AS WELL AS HIV TEST RESULTS, IF APPLICABLE), WHICH MAY BE NEEDED TO PROCESS CLAIMS FOR MEDICAL INSURANCE OR MANAGED CARE BENEFITS RELATIVE TO THIS HOSPITALIZATION (INCLUDING PRE-CERTIFICATION AND VERIFICATION, IF NECESSARY) OR THAT WHICH MAY BE NEEDED TO CONDUCT CONTINUED CARE PLANNING.</p>	
SIGNATURE:	DATE: