Patient Name _____

Scottsdale Healthcare Bariatric Center

Mail completed packet to:
10210 North 92nd Street, Suite 101
Scottsdale, Arizona 85258

480-882-7460

www.bariatricsurgeryaz.com

Seminars are held at:
All three Scottsdale Healthcare campuses and is also available online.
Please visit: www.bariatricsurgeryaz.com to register.

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Patient Name _____

Congratulations!

By considering the option to undergo weight loss surgery, you have taken the first step necessary to change your health…and your life. Please read the following information carefully.

Please do not print the packet double sided.

Steps in the Process:

1. **You must attend one of our free public educational seminars.** A list of our current seminars is located on our website **www.bariatricsurgeryaz.com** or call 480-882-4636.

2. **Confirm your insurance coverage for weight loss surgery.**

   Patients Paying Cash:

   Patients who have decided to pay cash either because they have no insurance benefit or because they do not want or are not able to meet the requirements of their insurance company go directly to #3 below.

   Note: If you are paying cash, you do not need to provide any supporting documentation of medically supervised weight loss programs, but you are required to lose 10% of your excess weight prior to surgery to participate in our program. You can easily do that during the process with the guidance of our registered dietician staff. If you have 100 pounds to lose, this would be 10 pounds prior to surgery.

   If you are going to use insurance to pay for your surgery:

   Contact your insurance carrier to determine whether you have a weight loss benefit as part of your insurance coverage.

   A common requirement is a six month medically supervised weight loss program, but there may be other specific requirements.

   Your insurance company may require a six month medically supervised weight loss program. You may opt to work within our system of care to complete your initial consult and preliminary requirements to expedite authorization for surgery. Options for completing the weight loss requirement are:
   1. A six month program through Scottsdale Healthcare Bariatric Center.
   2. Supervised weight loss with your primary care physician.
   3. Other Bariatricians providing this service which can be found on our website.

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OUT OF NETWORK:

If we are not a contracted provider for your insurance company, you may still choose to complete our program. You will be required to either pay the surgery fee or if you have out-of-network benefits you will be responsible for part of the fee.

3. **Complete and submit your new patient packet.**
   You must **completely fill out** your new patient packet and **sign it** in order for us to determine whether you're a candidate for surgery at Scottsdale Healthcare Bariatric Center. **Please complete this packet in ink.**
   - ☐ Include a **copy** (front and back) of your **insurance card** with your completed packet.

4. **Support documentation is now required** by all insurance companies for HMO, POS and PPO type plans. At you will need to provide:
   - ☐ A **letter** from your Primary Care Physician supporting your decision to undergo weight loss surgery. The physician will refer to this as a **letter of medical necessity**. We have attached a copy of a sample letter that you can give to your primary care doctor to complete.
   - ☐ **Documentation of all weight loss attempts** through diet centers and programs. This documentation includes enrollment cards and copies of office visits where weight loss programs were discussed. Documentation of your participation in a medically supervised weight loss program will help facilitate approval from your insurance company if required by your insurance.
   - ☐ If your insurance company requires a supervised medical weight loss period, we can help by having you work with our medical weight loss specialist. The cost of the program is $750 for 6 months and $26 for an EKG.

5. **Submitting your completed packet:**
   - **i. You can bring the packet, insurance information and supporting documentation to the public seminar, or**
   - **ii. Mail** your completed packet and documentation to:

     Scottsdale Healthcare Bariatric Center
     10210 North 92nd Street, Suite 101
     Scottsdale, Arizona 85258

     Please do not fax your completed new patient packet

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6. **When we have received your packet:**.
   - ☐ **We will verify your insurance benefit, co-pay and eligibility requirements. The new patient liaison will then call you to answer any questions you may have and help you develop a plan to complete the program.**
   - ☐ **For cash patients our New Patient Liaison will call you to schedule your initial consultation and answer any remaining questions you may have.**
   - ☐ All patient packets are evaluated for possible medical problems or special situations that might require a different pathway of care.
7. **Your initial consultation will include:**
   - ☐ A comprehensive health history and physical evaluation by the nurse practitioner or surgeon.
   - ☐ A nutritional evaluation by our staff Registered Dietician. This is now required by all insurance companies in order to obtain an authorization for surgery.
   - ☐ A comprehensive psychological evaluation and testing by our Licensed Clinical Psychologist specializing in Bariatric surgery.
   - ☐ A exercise consultation by our staff Exercise Physiologist.

Your initial appointment at SHBC will last approximately four to five hours. We will email you the confirmation of your appointment and a map to our office. If you cancel or reschedule an appointment please give several days notice.

PLEASE REMEMBER: If you did not submit a letter of medical necessity from your Primary Care Physician supporting your application for surgery, or your medically supervised weight loss documentation, **you MUST bring it with you** to your initial consultation.

AUTHORIZATION for surgery cannot be submitted without these documents.

That's it! You're now on your way to better health. While it's understandable that you may be anxious to schedule this life-changing event, we ***thank you for your patience*** *during this process.* ***At Scottsdale Healthcare Bariatric Center, we take every precaution to ensure your health, safety and long-term success.***

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Scottsdale Healthcare Bariatric Center
(The patient completes all information requested ***except when indicated***.)

Patient Name _____

Please complete in ink. **HEIGHT**_____**WEIGHT**_____

New Patient Information	**Name**	**Date of Birth**	**Gender (circle one)** Male · Female
Address/City/State/Zip			
Home Phone	**Cell Phone**	**Social Security No.**	
Marital Status (circle one) Single · Married · Divorced · Widow · Other	**E-mail Address***		
Employer	**Work Phone**		
Emergency Contact	**Emergency Contact Phone**		
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Internet · Direct Mailer · Other			

Insured Party Information	**Responsibility Party Name (if patient is under 18 OR other than patient)**	
Address/City/State/Zip		**Social Security No.**
Phone	**Date of Birth**	**Employer Name & Phone No.**

Physician Information	**Referring Physician/PCP (First Name, Last Name)**	**Phone**
Address/City/State/Zip	**Email**	**Fax**
Pharmacy:		**Phone**

Insurance Information	**Primary Insurance**	
Primary Insurance Address/City/State/Zip		
Policyholder Name (if other than patient)		**Social Security no**
ID/Policy No	**Group No**	**Primary Insurance Phone**
Secondary Insurance		**Phone**
Policy holder name(if other than patient)	**Social security no**	
ID/Policy No		**Group #**

A copy of both sides of the insurance cards needs to accompany this form.

I authorize my insurance company to pay directly any and all claims submitted by Scottsdale Healthcare Bariatric Center, PLC. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

Signature** _____ **Date** _____

* My signature on this document allows Scottsdale Healthcare Bariatric Center to communicate to me via my e-mail address.

** My signature on this document allows Scottsdale Healthcare Bariatric Center to request copies of any and all medical records from any source pertinent to my medical care.

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Patient Name _____

AUTHORIZATION TO RELEASE RECORDS

The following information is required:

Patient Name: _____ Social Security # _____

Address: _____ Date of Birth: _____

_____ Phone (Day): _____

I herby authorize release of my medical records:

TO: **Scottsdale Healthcare Bariatric Center** **Phone:** **480-882-7460**

Address: **10210 N. 92nd Street, Suite 101, Scottsdale, AZ 85258** **Fax:** **480-391-3898**

FROM: _____ **Phone:** _____

Address: _____ **Fax:** _____

At my request, purpose for release:

☐ Personal ☐ Continuing Care ☐ Insurance ☐ Legal
☐ Research ☐ Marketing ☐ Other: _____

☐ **All Records**
☐ **Other (please specify)** _____

Medical record reports covering date(s): _____ **to** _____

- I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information.
- This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without prejudice.
- I may revoke this authorization at any time providing I notify Scottsdale Healthcare Bariatric Center, in writing to this effect.
- I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.
- I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

This form must be completely filled out to process

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/Power of Attorney/Personal Representative Date

_____ _____
Records prepared and transmitted/Mailed by Date

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Patient Name _____

Patient History Questionnaire

Height _____**Weight**_____

The information requested in this questionnaire is very important. To give you the best care we must have complete answers. Please be thorough.

Name		**Date**
Age	**Gender (circle one)** Male · Female	**Occupation**

	Patient Measurement (Please Complete)	**Consult Measurement (Office Use)**	**Pre-Operative Measurement (Office Use)**
Height			
Initial Body Weight			
Ideal Body Weight			
Excess Body Weight			
10% Pre-op Excess Body Weight Loss Goal			
Target Weight			
Body Frame (circle one) Small Medium Large		***BMI***	***BMI***
		Waist	***Waist***
		Hips	***Hips***

Weight History

Please estimate as closely as possible for all that applies.

	Age	**Weight**
Birth Weight		
After Undergoing Puberty		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight. _____

_____

_____

_____

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Patient Name _____

Dietary History

Approximate age when you first seriously dieted. _____

List any ***physician***-supervised and documented weight loss attempt. _____

List any supervised and documented weight loss attempt. _____

List all other diets and/or weight loss attempts. _____

_____

List the diets and diet programs you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Jenny Craig	Yes · No			Yes · No	
Nutri-Systems	Yes · No			Yes · No	
Weight Watchers	Yes · No			Yes · No	
Opti/Medi Fast	Yes · No			Yes · No	
T.O.P.S.	Yes · No			Yes · No	
O.A.	Yes · No			Yes · No	
Other_____	Yes · No			Yes · No	

List the medications and treatments you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Fen/Phen/Redux	Yes · No			Yes · No	
Meridia	Yes · No			Yes · No	
Topamax/Topiramate	Yes · No			Yes · No	
Bontril/Phendimetrazine	Yes · No			Yes · No	
Tenuate/Diethylpropion	Yes · No			Yes · No	
Alli/Xenical	Yes · No			Yes · No	
HcG *Circle One: Shots or Oral*	Yes · No			Yes · No	
Acupuncture	Yes · No			Yes · No	
Other_____ *Such as SlimShots, Stacker, Cortislim, Xenadrine, Hydroxycut*	Yes · No			Yes · No	

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Patient Name _____

Weight Related Illnesses

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease ☐ Yes ☐ No Year diagnosed. _____
(check all that apply to you)

☐ Taking medications for heart disease [Check all that apply: ☐ ASA ☐ Coumadin ☐ Plavix]

☐ Angina ☐ M.I. (myocardial infarction) ☐ Stent #: _____

☐ Abnormal EKG ☐ CABG (coronary artery bypass graft)

☐ Palpitations ☐ Stress test to rule out cardiac problems

2. High Cholesterol ☐ Yes ☐ No Year diagnosed. _____
(check all that apply to you)

☐ High triglycerides ☐ Taking medications for high cholesterol

3. High Blood Pressure ☐ Yes ☐ No Year diagnosed. _____

☐ Taking medications for high blood pressure

Average pressure. _____

List dietary restrictions. _____

4. Pre-Diabetes ☐ Yes ☐ No Year diagnosed. _____

☐ Taking medications for pre-diabetes

5. Diabetes ☐ Yes ☐ No Year diagnosed. _____ How Diagnosed? ☐ FBG ☐ HgA1c ☐ Glucola Test

What type? ☐ Type I ☐ Type II ☐ Don't know

Gestational ..... ☐ Yes ☐ No

Controlled with..... ☐ Diet ☐ Medications ☐ Insulin

Last fasting blood sugar: _____ Date:_____

Last HgA1c: _____ Date:_____

Complications of T2DM: ☐ Neuropathy ☐ Kidney Disease ☐ Vascular Disease ☐ Amputation

6. Asthma ☐ Yes ☐ No Year diagnosed. _____

☐ Taking medications for asthma

ER visits in last 2 years. _____

Hospitalizations in last 2 years. _____

Steroids used in last 2 years ..... ☐ Yes ☐ No

7. Reactive Airway Disease (RAD) ☐ Yes ☐ No Year diagnosed. ____

Age at diagnosis _____ ☐ Taking medications for RAD

What exacerbates RAD? _____

Take which inhaler for RAD? _____

Take which steroids for RAD? _____

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Patient Name _____

8. Sleep Apnea Syndrome
(check all that apply to you regardless if you have been diagnosed with sleep apnea or not)

Morning headaches ..... ☐ Yes ☐ No

Daytime drowsiness ..... ☐ Yes ☐ No

Restless sleep ..... ☐ Yes ☐ No

Snoring ..... ☐ Yes ☐ No

Awakenings at night ..... ☐ Yes ☐ No
(including choke or gasp)

Observed apnic episodes ☐ Yes ☐ No

Last sleep study (month/year) _____

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No Year diagnosed. _____

CPAP used ..... ☐ Yes ☐ No Setting _____

10. Barrett's esophagitis ☐ Yes ☐ No Year diagnosed. _____
Endoscopy ..... ☐ Yes ☐ No

11. Hiatus hernia ☐ Yes ☐ No Year diagnosed. _____
Upper GI series ..... ☐ Yes ☐ No
Endoscopy ..... ☐ Yes ☐ No

12. Gastroesphageal reflux (GERD) ☐ Yes ☐ No Year diagnosed. _____
☐ Taking medications for GERD

13. Gallbladder disease ☐ Yes ☐ No

How was it diagnosed? ..... ☐ Ultrasound ☐ Physical exam Year diagnosed: _____

Did you have your gallbladder removed? ☐ Yes ☐ No

If yes, was it removed: ☐ Laparoscopically ☐ Open procedure

14. Stress Incontinence (Leakage of urine with laughing/coughing/sneezing) ☐ Yes ☐ No
Wear pads frequently ..... ☐ Yes ☐ No

15. Diagnosis of Chronic Joint Disease ☐ Yes ☐ No

How was it diagnosed? ..... _____ Year: _____

What treatments have been prescribed to you by a medical doctor (check all that apply):

☐ Physical therapy ☐ Lifestyle modification

☐ Medication Type of medication: _____

☐ Surgery Type of surgery: _____

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Patient Name _____

16. Diagnosis of plantar fasciitis ☐ Yes ☐ No

How was it diagnosed? ....._____ Year: _____

What treatments have been prescribed to you by a medical doctor (check all that apply):

☐ Physical therapy ☐ Splints/Inserts

☐ Medication Type of medication: _____

☐ Surgery Type of surgery: _____

15. Can you walk unassisted? ☐ Yes ☐ No

If **no**, do you use a: cane .....☐ Yes ☐ No
walker.....☐ Yes ☐ No
wheelchair.....☐ Yes ☐ No

16. Weight related injuries and trauma _____

17. Swelling in legs ☐ Yes ☐ No

18. Thyroid disease ☐ Yes ☐ No

☐ Taking medications for thyroid disease

19. Do you have a personal history of blood clots in your arms, legs or lungs? ☐ Yes ☐ No

20. Have you ever been on a blood thinner to prevent or treat the formation of blood clots? ☐ Yes ☐ No

If yes, which medication:

☐ Warfarin ☐ Coumadin ☐ Lovenox ☐ Heparin ☐ Other _____

21. Do you have any personal history of problems with your blood being too thin or too thick? ☐ Yes ☐ No

22. Deep Venous Thrombosis ☐ Yes ☐ No

23. Pulmonary Embolism ☐ Yes ☐ No

24. Hepatitis ☐ Yes ☐ No

Which type (circle one): A B C Unknown

25. Cancer ☐ Yes ☐ No

Type: _____

Treatment: _____

26. Irregular period or infertility (FOR FEMALE PATIENTS ONLY) ☐ Yes ☐ No

If yes, please explain: _____

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Patient Name _____

Past Medical History

Please identify which of the following ***childhood*** illnesses and operations you have experienced.

	Age	Year
Rheumatic fever		
Appendectomy		
Tonsillectomy		

Please list below all serious illnesses and hospitalizations you have experienced in ***adulthood***.

☐ **No Major Illness** ☐ **No Major Surgery**

Major Illness	Date	Treatment

Major Surgery	Date	Open or Laparoscopic

FOR FEMALE PATIENTS ONLY:

Age at first period: **Date of last period:**

Total # of Pregnancies: **# of live births:** **# of miscarriages/abortions:**

	Year	Weight at Start	Weight at Delivery
Pregnancy #1			
Pregnancy #2			
Pregnancy #3			
Pregnancy #4			

What were the birth weights of your children: Child #1: _____ Child #2: _____ Child #3: _____

Obstetric complications. : _____

_____

_____

Preeclampsia: _____ Hypertension during Pregnancy: _____ HELP syndrome: _____

Tachycardia of pregnancy? _____

Do you have Polycystic Ovarian Syndrome? Y N Age at diagnosis:_____

Do you consider yourself infertile? Y N Have you undergone any treatment for infertility? Y N

Do you presently use: Birth control pills.....☐ Yes ☐ No List type. _____

Estrogens.....☐ Yes ☐ No List type. _____

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Patient Name _____

Allergic to surgical tape. ☐ Yes ☐ No

If **yes**, please list reaction. _____

Allergic to latex. ☐ Yes ☐ No

If **yes**, please list reaction. _____

Allergic to any medications. ☐ Yes ☐ No

If **yes**, please list medication and reaction. _____

Current Medications ☐ Not on any medications

Please list **ALL** medications, including supplements, you currently use, including dose, frequency and reason for use. Please be accurate and use your prescription bottles to assist you with the spelling.

Medication	Dose and Frequency	Reason

Do you use tobacco? ☐ Yes ☐ No Frequency. _____

Are you willing to quit? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Frequency. _____

Do you use illegal substances? ☐ Yes ☐ No

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Patient Name _____

	Living (circle one)	Current Age (if living)	Deceased at Age	Illness/ Cause of Death	Overweight/Obese
Mother	Yes · No				Yes · No
Father	Yes · No				Yes · No
Maternal Grandmother	Yes · No				Yes · No
Maternal Grandfather	Yes · No				Yes · No
Paternal Grandmother	Yes · No				Yes · No
Paternal Grandfather	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No
Sibling	Yes · No				Yes · No

Please check if there is a family history of:

- ☐ high blood pressure
- ☐ high blood cholesterol
- ☐ bleeding tendency or blood disorder
- ☐ lung disease, asthma or emphysema
- ☐ Hepatitis A B C Unknown (**circle one)**
- ☐ obesity
- ☐ diabetes
- ☐ heart disease
- ☐ deep vein thrombosis
- ☐ colon cancer
- ☐ breast cancer
- ☐ kidney disease
- ☐ pulmonary embolism

Please list all the physicians whose care you are under. Please complete this section in full.

	First Name, Last Name	Address/City/State/Zip	Telephone	Email
Primary Care Physician				
Internist				
Gynecologist				
Orthopedist				
Psychiatrist				
Psychologist				
Therapist				
Other				

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Patient Name _____

System Review

Please check all symptoms that you have or have had. Write in any additional problems.

Head, Eye, Ear, Nose, and Throat ☐ No Complaints

☐ vertigo	☐ headache	☐ sinus problems	☐ balance disturbances
☐ pain in/around ears	☐ nasal congestion	☐ double vision	☐ decreased night vision
☐ dizziness	☐ nasal drainage	☐ lump in throat	☐ dysphasia
☐ Rhinitis	☐ hoarseness	☐ ringing in ears	☐ ear drainage
☐ sore throat	☐ blurred vision	☐ hearing loss	☐ visual aura
☐ Uvulectomy	☐ buzzing in ears	☐ pain with swallowing	

Respiratory ☐ No Complaints

☐ cough	☐ bronchitis	☐ blood in sputum	☐ wake up at night short of breath
☐ asthma	☐ emphysema	☐ out of breath with exertion	☐ wake up at night coughing or choking
☐ wheezing	☐ use two pillows	☐ shortness of breath at night	☐ _____

Cardiovascular ☐ No Complaints

☐ cold feet	☐ heart attack	☐ heart murmur	☐ squeezing of chest
☐ blue toes	☐ pains in neck	☐ loss of pulses	☐ skipping of heartbeat
☐ blue finger	☐ pains in arms	☐ pounding of heart	☐ high blood pressure
☐ palpitations	☐ pains in chest	☐ irregular heartbeat	☐ abnormal electrocardiogram
☐ pain in legs	☐ _____		

Gastrointestinal ☐ No Complaints

☐ colitis	☐ vomiting	☐ irritable colon	☐ burning in stomach
☐ cramps	☐ heartburn	☐ acid stomach	☐ food sticking in chest
☐ nausea	☐ gassiness	☐ blood in stools	☐ belching fluid in throat
☐ fissures	☐ constipation	☐ burning in throat	☐ pain with bowel movement
☐ diarrhea	☐ hemorrhoids	☐ pains in stomach	☐ _____

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Patient Name _____

Genitourinary ☐ No Complaints

☐ nephritis ☐ kidney stones ☐ pain with urination ☐ trouble stopping urine
☐ blood in urine ☐ bladder stones ☐ small urine stream ☐ urinary tract infections
☐ kidney failure ☐ frequent urination ☐ trouble starting urine ☐ getting up at night to urinate
☐ leakage of urine with cough or sneeze ☐ _____

Men ☐ No Complaints

☐ loss of erection ☐ painful erection ☐ discharge from penis ☐ _____

Women ☐ No Complaints

☐ irregular periods ☐ vaginal bleeding ☐ vaginal discharge ☐ pain with intercourse
☐ _____

Endocrine (Glandular) ☐ No Complaints

☐ goiter ☐ hyperthyroid ☐ grave's disease ☐ adrenal gland tumor
☐ diabetes ☐ x-ray to thyroid ☐ frequent flushing ☐ frequent heavy sweating
☐ low thyroid ☐ thyroid nodules ☐ _____

Musculoskeletal ☐ No Complaints

☐ flatfeet ☐ foot pain ☐ slipped disk ☐ broken bones
☐ sprains ☐ knee pain ☐ fluid in joints ☐ herniated disk
☐ arthritis ☐ ankle pain ☐ pain in joints ☐ swelling of joints
☐ sciatica ☐ warm joints ☐ low back pain ☐ redness of skin over joints
☐ hip pain ☐ _____

Neurological ☐ No Complaints

☐ fits ☐ fainting ☐ convulsions ☐ twitching of muscles
☐ tremor ☐ dizziness ☐ falling at night ☐ loss of consciousness
☐ vertigo ☐ shakiness ☐ falling to the side ☐ pins & needles feelings
☐ tingling ☐ numbness ☐ weakness of grip ☐ weakness of any muscles
☐ _____

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Patient Name _____

Psychological ☐ No Complaints

☐ major depression (once)

when? _____

☐ major depression (twice or more)

last episode? _____

☐ posttraumatic stress disorder

☐ borderline personality disorder

☐ schizophrenia

☐ schizoaffective disorder

☐ bipolar disorder

☐ manic depression

☐ dissociative disorder

☐ dissociative identity disorder

☐ multiple personality disorder

☐ alcohol abuse/dependency

☐ drug abuse/dependency

☐ psychotic disorder

☐ anorexia

☐ bulimia

☐ generalized anxiety disorder

☐ panic disorder

☐ panic attacks

☐ obsessive compulsive disorder

☐ in-patient hospitalization

when? _____

condition? _____

☐ psychotherapy

when? _____

condition? _____

How did you hear about Scottsdale Healthcare Bariatric Center (please check one).

☐ Electronic Newsletter

☐ Family

☐ Friend

☐ Magazine

☐ Newspaper

☐ Physician referral

☐ Radio

☐ Search Engine

☐ T.V.

☐ Website

☐ Other (please explain) _____

Have you attended a Scottsdale Healthcare Bariatric Center Informational Seminar?

☐ No

☐ Yes

☐ When and Where? _____

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Patient Name _____

Race:
(Please select one or more options)

- ☐ White
- ☐ Black or African American
- ☐ American Indian and Alaska Native
  - Tribal Affiliation _____
- ☐ Other race
- ☐ Asian (Please specify)
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Native Hawaiian and Other Pacific Islander (Please specify)
  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander

Ethnicity:
(Please select one or more options)

- ☐ Hispanic or Latino (of any race):
  - ☐ Mexican
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Other Hispanic or Latino: _____
- ☐ Not Hispanic or Latino

Clinical Study Participation:

Scottsdale Healthcare Bariatric Center strives to provide our patients with various methods of achieving weight loss and is currently participating in clinical trials of new devices being tested for use in overweight/obese patients. If you are interested in participating in one of these clinical trials or want to at least discuss participation, check this box.

☐ **Yes, I am interested in learning more about the clinical studies being performed at Scottsdale Healthcare Bariatric Center**

☐ **No, I am not interested at this time.**

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Patient Name _____

Exercise

If you are able to exercise, what kinds of exercise do you do?

Type of Exercise	Duration (how long each time)	Frequency (times per week)

Food Preferences

Indicate which foods you prefer (which foods would most likely make you go off a diet).
Rank each selection from **1–like very much** to **4–don't care**.

____ **candy**	____ **ice cream**	____ **cakes/pies**	____ **steaks/chops**
____ **pizza**	____ **potatoes**	____ **fried foods**	____ **salad dressings**
____ **pasta**	____ **chocolate**	____ **chips/snacks**	____ **soda/soft drinks**
____ **cookies**	____ **french fries**		

How many times per week do you eat out: 1 2 3 4 5 6 7 or more

Estimated number of calories you normally eat per day: _____

Food Diary

Please write down everything you ate or drank over the last 7 days.

	Date (Month/Day)	Breakfast	Lunch	Dinner	Other
1					
2					
3					
4					
5					
6					
7					

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Patient Name _____

Scottsdale Healthcare Bariatric Center
Diagnostic Questionnaire

The following questions are to help us determine a well suited program for your success. Please answer questions accurately to the best of your ability.

1. Are you a large volume eater at mealtimes with minimal snacking between?
   YES NO

2. Do you react to stress by eating or snacking? YES NO

3. Do you consider yourself typically well disciplined and focused? YES NO

4. Name your top three favorite foods?

a_____ b. _____ c._____

5. Do you like to eat after 7pm? YES NO

6. Do you have either diabetes or insulin resistance? YES NO

7. Have you had successful weight loss in the past? YES NO
   a. If so, your maximum weight loss? _____ lbs.
   b. How long did it take you? _____

8. Can you refrain from drinking alcohol**?** YES NO

9. Are you dependant on anti-inflammatory agents**?** YES NO

10. Name stressors or triggers which may cause inappropriate eating?

_____, _____, _____, _____,

11. Which bariatric service are you most interested in?

___Medical Weight Loss Program, ___ Adjustable Gastric Band, ___ Sleeve

___ Lap Gastric Bypass, ___ BPD/Duodenal Switch, ___ Revision

___ Other: _____

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Sample letter of medical necessity

(*INSERT LETTERHEAD HERE*)

(*Date*)

Scottsdale Healthcare Bariatric Center
10210 N. 92nd St #101
Scottsdale, AZ 85258

Re: (*insert patient name*)
Letter of Medical Necessity

To whom it may concern:

(*patient name*) is a (*age*) year-old male/female with a current weight of *(weight*) and a BMI of (*BMI).* He/She has *(insert co-morbidities and any treatments being used).* He/She has tried many diets in the past including (*insert diets used and the outcomes*).

I believe *(insert patient name*) would benefit from weight loss surgery and have I have referred him/her to Scottsdale Healthcare Bariatric Center, which is an American Society of Bariatric Surgeons, National Center of Excellence.

Sincerely,

(*Signature*)

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Patient Name _____

Scottsdale Healthcare Bariatric Center
Surgical Fee Disclosure
Laparoscopic Gastric Bypass
Self-pay Discount Prices

New Patient Consultation includes:	
Physicians consult	**$ 350.00**
Psychological testing/evaluation	**$ 325.00**
Surgical Fee-gastric bypass	**$ 7,700.00**
(Surgery fee includes 90 days of follow-up in the office)	
Facility Fee Scottsdale Healthcare Shea	**$ 14,500.00**
Anesthesiologist	**$ 1,500.00**
(Valley anesthesia will contact you within two weeks of surgery)	
TOTAL:	**$ 24,375.00**

Miscellaneous - (ESTIMATE)	**$ 1,000.00**

(This is an estimate of lab work, chest x-ray and EKG that may be required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary care doctor)

Additional Procedures, SHOULD YOU NEED THEM:

Removal of Gallbladder	**$ 750.00**
Hernia Repair	**$ 750.00**
Liver Biopsy	**$ 350.00**

(The hospital may have additional fees also)

The medical need for a secondary surgical procedure cannot always be predicted prior to surgery.

Payment for the Hospital will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Scottsdale Healthcare **480-323-3168**

Valley Anesthesia **480-748-2812**

A deposit of $3,850.00(is usually ½ of the surgical fee) is required to schedule a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon. Total payments for the surgical fees are due 30 days prior to surgery. Cancellation after that date will result in a 50% cancellation fee. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital. Initial_____

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure. The medical need for a secondary surgical procedure cannot always be predicted prior to surgery. If a complication may occur and an additional surgery is required, that surgery is billed separately and you will be responsible for your portion.

Initial_____

I acknowledge the above and agree to the stated fees and wish to move ahead with consultation.

_____ _____

Signature **Date**

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Patient Name _____

Scottsdale Healthcare Bariatric Center
Surgical Fee Disclosure
Laparoscopic Gastric Sleeve
Self-pay Discount Prices

New Patient Consultation includes:	
Physician consults	**$ 350.00**
Psychological testing/evaluation	**$ 325.00**
Surgical Fee-Gastric Sleeve	**$ 5,220.00**
(Surgery fee includes 90 days of follow-up in the office)	
Facility Fee Scottsdale Healthcare Shea	**$ 12,780.00**
Anesthesiologist	**$ 1,600.00**
(Valley anesthesia will contact you within two weeks of surgery)	
TOTAL:	**$ 20,275.00**
Miscellaneous - (ESTIMATE)	**$ 1,000.00**

(This is an estimate of lab work, chest x-ray and EKG that may be required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary care doctor)

Additional Procedures, SHOULD YOU NEED THEM:

Removal of Gallbladder	**$ 750.00**
Hernia Repair	**$ 750.00**
Liver Biopsy	**$ 350.00**
(The hospital may have additional fees also)	

Payment for the Hospital will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Scottsdale Healthcare	**480-323-3168**
Valley Anesthesia	**480-748-2812**

A deposit of $2,610.00 **(is usually ½ of the surgical fee)** is required to reserve a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon. Total payment for the surgical fees is due prior to surgery. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital. Initial_____

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure. The medical need for a secondary surgical procedure cannot always be predicted prior to surgery. If a complication may occur and an additional surgery is required, that surgery is billed separately and you will be responsible for your portion.
Initial_____

I acknowledge the above and agree to the stated fees and wish to move ahead with consultation.

_____ _____
Signature **Date**

©2014 Scottsdale Healthcare Bariatric Center

Patient Name _____

Scottsdale Healthcare Bariatric Center
Surgical Fee Disclosure
Laparoscopic Gastric Band
Self pay Discount Prices

New Patient Consultation includes:	
Physician consults	**$ 350.00**
Psychological testing/evaluation	**$ 325.00**
Surgical Fee Laparoscopic Gastric Band	**$ 4,650.00**
(Surgery fee includes 90 days of follow-up in the office)	
Facility Fee Scottsdale Healthcare Shea	**$ 10,350.00**
Anesthesiologist	**$ 900.00**
(Valley anesthesia will contact you within two weeks of surgery)	
TOTAL:	**$ 16,575.00**

Miscellaneous - (ESTIMATE) **$ 1,000.00**
(This is an estimate of lab-work, chest x-ray and EKG that may be required prior to surgery. You may be able to use your insurance for some of these fees. Once you are scheduled for surgery, we will give you orders for these tests so you can take to your primary care doctor.)

Additional Procedures, SHOULD YOU NEED THEM:

Removal of Gallbladder	**$ 750.00**
(This may be billable to your insurance)	
Hernia Repair	**$ 750.00**
Liver Biopsy	**$ 350.00**
(The hospital may have additional fees also)	

Payment for the Hospital will be made at the time of your preoperative education class at the hospital, which is usually two to three weeks prior to surgery. Contacts for the hospital and anesthesia, should you need them:

Scottsdale Healthcare	**480-323-3168**
Valley Anesthesia	**480-748-2812**

A deposit **of $2,325.00** **(is usually ½ of the surgical fee)** is required to reserve a surgery date. The balance of the surgical fee is due at your pre-operative visit with the surgeon. Total payment for the surgical fees is due prior to surgery. Should any additional procedures be necessary, the remaining amount will be billed to you post-operatively and is due upon receipt. Fees quoted are representative of Scottsdale Healthcare Bariatric Center only. You may incur additional professional fees while in the hospital. Initial_____

When a laparoscopic procedure is converted to an open incision, the fee remains that for a laparoscopic procedure. The medical need for a secondary surgical procedure cannot always be predicted prior to surgery. If a complication may occur and an additional surgery is required, that surgery is billed separately and you will be responsible for your portion.
Initial_____

I acknowledge the above and agree to the stated fees and wish to move ahead with Consultation.

_____ _____
Signature **Date**

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