
PATIENT INFORMATION PROFILE

MIDTOWN SURGICAL SPECIALISTS

SPECIALISTS IN GENERAL AND VASCULAR SURGERY

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) (Marital status)

(Area code) (Phone #) (Cell #) (Work #)

(email address)

(Social Security #) (employer) (employer phone # & ext.)

=====

(Spouse's name) (Spouse's employer & phone #)

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

=====
Please state reason for seeing doctor today: _____

Dr. that referred you here: _____ Primary Care Physician: (PCP)_____

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.

Signature: _____ **Date** _____

Family History	
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	

Social History	
Occupation:	
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered
Tobacco use:	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently (list packs/day and # of years)
Alcohol:	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily

Review of Symptoms	
Check the boxes that apply to YOU.	
Constitutional:	<input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexplained weight loss
Eyes:	<input type="checkbox"/> Recent change in vision
Cardiovascular:	<input type="checkbox"/> Heart attack or chest pain <input type="checkbox"/> Pain in legs with walking <input type="checkbox"/> History of stroke <input type="checkbox"/> History of cardiac cath <input type="checkbox"/> Heart Palpitation
ENT:	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sores/Lesions in mouth
Respiratory:	<input type="checkbox"/> Excessive shortness of breath <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Use home oxygen <input type="checkbox"/> Use CPAP or BIPAP <input type="checkbox"/> Chronic/Persistent cough
Gastrointestinal:	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Recent blood in stool <input type="checkbox"/> Heart Burn <input type="checkbox"/> History of stomach ulcers
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"/> New skin lesions/moles <input type="checkbox"/> Breast mass <input type="checkbox"/> Nipple discharge
Neurological:	<input type="checkbox"/> History of seizures
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder
Endocrine:	<input type="checkbox"/> Hot/Cold episodes <input type="checkbox"/> History of thyroid disease
Hematology/Lymphatic	<input type="checkbox"/> Bleeding abnormality <input type="checkbox"/> history of blood clots
Allergy/Immunology:	<input type="checkbox"/> Problems with anesthesia <input type="checkbox"/> Latex or tape allergy

Please list any other symptoms you are having in this area:

The above is true and correct to the best of my knowledge. (Please sign below)

Signature _____ **Date** _____

What is the biggest reason you are interested in weight loss surgery: _____

What are your weight loss goals: _____

What have you done to research the option of weight loss surgery?

- Internet research
- Information Session
- Books
- Other Patients

WEIGHT HISTORY

Please indicate your weight at the following times during your life.
Use the empty boxes for other significant life events

Age	weight	Notes
preteen		
18		
25		
30		
35		
40		
50		
60		
Pregnancies		
Marriage (age)		

AGE FIRST AT THE FOLLOWING WEIGHTS:

150 LBS _____

300 LBS _____

200 LBS _____

350 LBS _____

250 LBS _____

400 LBS _____

LIFE MILE STONES THAT HAVE CONTRIBUTED TO YOUR WEIGHT GAIN (EG: PREGNANCIES, DEATH OF LOVED ONES, MARRIAGE, SURGERY, INJURIES, ETC):

MEDICAL WEIGHT LOSS HISTORY

For how long have you been seriously trying to lose weight? _____ years

Rate your seriousness at dieting attempts: 0-----10

Rate how desperately you want to lose weight 0-----10

Rate how frustrated are you with medical weight loss programs: 0-----10

What are you willing to do to loose and maintain a significant amount of weight loss?: _____

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

What did you do to loose 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?

Dieting - fad diets, something you have read about, etc

Adkins Diet when (age/year): _____ Wt Lost _____

South Beach when (age/year): _____ Wt Lost _____

Grapefruit Diet when (age/year): _____ Wt Lost _____

Cabbage Soup Diet when (age/year): _____ Wt Lost _____

Other _____ when (age/year): _____ Wt Lost _____

Exercise - walking, swimming, sporting activities, etc

Gym Membership when (age/year): _____ Wt Lost _____

Personal Trainer when (age/year): _____ Wt Lost _____

Other _____ when (age/year): _____ Wt Lost _____

If you don't exercise, why not? _____

Commercial weight loss programs:

Jenny Craig when (age/year): _____ Wt Lost _____

Weight Watchers when (age/year): _____ Wt Lost _____

PHC when (age/year): _____ Wt Lost _____

Nutrisystem when (age/year): _____ Wt Lost _____

Herbal Life when (age/year): _____ Wt Lost _____

LA weight Loss when (age/year): _____ Wt Lost _____

Others - please list: _____

Diet Pills:

Fenteramine when (age/year): _____ Wt Lost _____

Phen/Fhen when (age/year): _____ Wt Lost _____

Adipex when (age/year): _____ Wt Lost _____

Xenical when (age/year): _____ Wt Lost _____

Redux when (age/year): _____ Wt Lost _____

OTC Medication when (age/year): _____ Wt Lost _____

Other _____ when (age/year): _____ Wt Lost _____

Professional Advice:

Family Doctor when (age/year): _____ Wt Lost _____

Weight Loss Specialist/MD when (age/year): _____ Wt Lost _____

Dietitian when (age/year): _____ Wt Lost _____
Psychologist when (age/year): _____ Wt Lost _____
Other _____ when (age/year): _____ Wt Lost _____

Very low calorie diets

Medifast when (age/year): _____ Wt Lost _____
Optifast when (age/year): _____ Wt Lost _____

PHYSICAL EFFECTS OF OBESITY

What is the single biggest reason you are considering weight loss surgery: _____

Do you suffer any of the following physical limitations because of your weight?

- | | | |
|---|------------------------------|-----------------------------|
| Get short of breath easily | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Always tired and lethargic | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cannot take part in family outdoor activities | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have difficulty buying clothes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have difficulty with personal hygiene | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cannot cut your toenails/tying shoes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulty sitting in chairs with arms | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Travel, especially in planes, is difficult | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

What is the biggest limitation your weight presents in your life: _____

List any other particular difficulties that your weight is currently causing in your life: _____

SLEEP HISTORY

How many hours sleep do you get a night? _____

To answer each question, mark the horizontal line with an "X" in the position that best indicates your answer.

1. How often do you snore?

NEVER _____ ALWAYS

2. Do you wake during the night with a choking feeling?

NEVER _____ FREQUENTLY

3. How often would you sleep more than 8 hours in total in a 24 hour period?

NEVER _____ ALWAYS

4. How often do you doze off or fall asleep while driving?

NEVER _____ ALWAYS

5. Do you have a headache when you wake up in the morning?

NEVER _____ ALWAYS

6. Have you noticed a reduction in your libido or sex drive?

NO _____ TOTAL

7. Do you feel sleepy during the day?

NEVER _____ ALWAYS

8. Has anyone noticed that you momentarily stop breathing during your sleep?

NO _____ FREQUENTLY

9. Do you fall asleep while reading?

NEVER _____ FREQUENTLY

10. Do you wake up in the morning feeling confused?

NEVER _____ ALWAYS

11. How often do you have a nap during the day?

NEVER _____ ALWAYS

12. Do you feel sleepy in the evenings?

NEVER _____ ALWAYS

Diet History

What is your daily schedule:

When do you get up: _____

What are your work hours: _____

When do you go to bed: _____

Other: _____

Meals: describe in general a typical day of eating

Meal	Time	Where	What
Breakfast			
snack			
Lunch			
snack			
Dinner			
snack			

Beverages (regular sodas, diet sodas, tea sweet/unsweet, juices, crystal light, etc)

Beverage	How Much	When/What Meal

PATIENT ACKNOWLEDGMENT FORM

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

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

I understand that Midtown Surgical Specialists., P.C. 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. 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.

Midtown Surgical Specialists, P.C. 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 aren't limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

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

Midtown Surgical Specialists., P.C. 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 Midtown Surgical Specialists., P.C. by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Midtown Surgical Specialists., PC's "Notice of Privacy Practices".

Signature: _____ Date: _____

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

With this consent, Midtown Surgical Specialists., P.C. may call my home or other alternative location and leave a message on voice mail or in person 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 tests results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Midtown Surgical Specialists., P.C. 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.

Signature: _____ Date: _____

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

Printed name of Patient and/or Personal Representative: _____

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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 will 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 (deductibles). We appreciate payment in full within 10 days. 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 use of:
 - a. Payment with a credit card
 - b. Extension of a line of credit through a medical services credit company
 - c. Establishing a monthly payment contract with our office
3. Statements will be mailed to you monthly for 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.
4. Prior to elective surgery we will confirm benefits and 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 appreciate payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing afterwards.
5. **Questions or concerns regarding your bills should be addressed directly with the billing staff and not your physician.**
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.

Patient Signature

Date