Advanced Laparoscopic Surgeons

New Patient Intake Form

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:			❑ Male ❑ Female
Birthdate:	Soc. Sec. no.:		Marital status: ❑ S ❑ M ❑ D ❑ W
Mailing address:		Apt no.:	
City:		State:	Zip:
Home Phone:	Cell Phone :		
Reason for this visit:			
Height: _____ft. _____in.	Weight: _____ lbs.	Email Address:	

EMPLOYER INFORMATION: ❑Full Time ❑Unemployed ❑Student ❑Retired ❑Disability			
Employer/School name:			
Patient occupation:		Work phone no:	
Employer address:			
City:		State:	Zip:

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 employer:		Insured's occupation:	

SECONDARY INSURANCE INFORMATION ❑ None			
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 employer:		Insured's occupation:	
Employer's address:		Work phone no.:	
City:		State:	Zip:

Advanced Laparoscopic Surgeons of Morris, LLC 83 Hanover Road, Suite 190, Florham Park, NJ 07932
Phone 973.410.9700 Fax 973.410.9703 E-Mail info@alsnj.com

INSURANCE AUTHORIZATION

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.

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.

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.

SIGNATURE: DATE:

Signature of person responsible for payment

NEAREST RELATIVE

Name:	Relationship to patient:
Home phone no:	Work phone no:

PAST MEDICAL/SURGICAL HISTORY

Please list any health condition(s) for which you are currently being treated (i.e., diabetes, sleep apnea, high blood pressure, etc.) and the date you were diagnosed.

1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:
7.	Date:
8.	Date:

Previous Surgeries / Procedures / Hospitalizations:

1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:

Previous Bariatric Surgery

Surgery	Surgeon	Date	Weight Lost	Weight Regained

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Allergies: (Drugs, latex, environmental, other)	**Reaction:**

Current Medications: (List daily medications, pain medication as well as those used as needed)			
Medication:	**Dosage:**	**How often?**	**Condition:**

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:**
Primary Care:		
Pulmonologist:		
Gastroenterologist:		
Orthopedist:		
Neurologist:		
Cardiologist:		
Psychiatrist:		
Endocrinologist:		
Gynecologist:		
Other:		

Personal Habits:		
Do you smoke?	❑ Yes ❑ No	How much?
How long?	❑ Yes ❑ No	When did you quit?
Do you drink alcohol	❑ Yes ❑ No	How much?
Do you use drugs?	❑ Yes ❑ No	What kind/How often?
Have you ever used drugs?	❑ Yes ❑ No	

Family History:

Relationship:	Age:	Health:	If deceased, cause:	Weight:
Father:		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Mother:		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Sibling ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Sibling ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Sibling ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Sibling ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Sibling ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Child ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Child ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Child ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Child ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight
Child ❑M ❑F		❑ Good ❑ Fair ❑ Poor		❑ Thin ❑ Average ❑ Overweight

Do you know of any blood relative who has or had: (Check and give relationship)

Stroke	❑	Heart Disease	❑	Bleeding tendency	❑
High blood pressure	❑	Cancer	❑	Problems with anesthesia	❑
Diabetes	❑	Tuberculosis	❑	Overweight (20 - 99 lbs.)	❑
Obese (over 100 lbs.)	❑	Other (Explain):			

Review of Systems: Neurologic

Have you ever fainted:	Yes ❑ No ❑	Have you ever had a convulsion?	Yes ❑ No ❑
Double vision?	Yes ❑ No ❑	Weakness in arms/legs?	Yes ❑ No ❑
Ringing in ears?	Yes ❑ No ❑	Visual disturbances?	Yes ❑ No ❑
Severe headaches?	Yes ❑ No ❑	Do headaches awaken you at night?	Yes ❑ No ❑
Pain on one side of head?	Yes ❑ No ❑	What relieves headaches?	

Review of Systems: Cardio respiratory

Have you had shortness of breath?

Doing normal work?	Yes ❑ No ❑	Climbing flights of stairs?	Yes ❑ No ❑
Does it awaken you at night?	Yes ❑ No ❑	Accompanied by wheezing?	Yes ❑ No ❑
Do you have a chronic cough?	Yes ❑ No ❑	Do you cough up sputum?	Yes ❑ No ❑
Do you have palpitations?	Yes ❑ No ❑	Do you have phlebitis or inflamed leg veins?	Yes ❑ No ❑
Do you have swollen ankles?	Yes ❑ No ❑	Do you have varicose veins?	Yes ❑ No ❑
Do you have bleeding problems?	Yes ❑ No ❑	Do you need more than one pillow to sleep?	Yes ❑ No ❑

Have you ever had chest pain or tightness:			
When exerting yourself?	Yes ❑ No ❑	When excited or upset?	Yes ❑ No ❑
After a heavy meal?	Yes ❑ No ❑		
Does the chest pain:			
Radiate to the arm, neck or back?	Yes ❑ No ❑	Occur only at rest?	Yes ❑ No ❑
Abate when you rest?	Yes ❑ No ❑		
Review of Systems: Psychiatric			
Do you have a history of psychiatric illness? Yes ❑ No ❑			
Anxiety?	Yes ❑ No ❑	Depression?	Yes ❑ No ❑
Suicide attempts?	Yes ❑ No ❑	Obsessive-compulsive disorder?	Yes ❑ No ❑
Bi-polar or manic depression?	Yes ❑ No ❑	Hospitalizations?	Yes ❑ No ❑
Review of Systems: Gastrointestinal			
Do you have reflux or GERD? Yes ❑ No ❑			
Have you had pain in the stomach which:			
Occurs 1 or 2 hours after meals?	Yes ❑ No ❑	Is brought on by eating fried / greasy foods?	Yes ❑ No ❑
Awakens you at night?	Yes ❑ No ❑	Is relieved by eating?	Yes ❑ No ❑
Is relieved by antacid medications?	Yes ❑ No ❑	Occurs while eating or immediately after?	Yes ❑ No ❑
Is relieved by bowel movement?	Yes ❑ No ❑		
Do you have:			
Abdominal cramps?	Yes ❑ No ❑	Alternating diarrhea and constipation?	Yes ❑ No ❑
Pain during or after bowel movements?	Yes ❑ No ❑	Mucous in the stool?	Yes ❑ No ❑
Black stools?	Yes ❑ No ❑		
Review of Systems: Genitourinary			
Have you had:			
Burning when urinating?	Yes ❑ No ❑	Loss of bladder control?	Yes ❑ No ❑
Stress incontinence?	Yes ❑ No ❑	Blood in the urine?	Yes ❑ No ❑
Dark-colored urine?	Yes ❑ No ❑	Trouble starting to urinate?	Yes ❑ No ❑
Trouble holding the urine?	Yes ❑ No ❑	Frequency/awakening at night?	Yes ❑ No ❑
Have you passed a kidney stone?	Yes ❑ No ❑		
Men Have you had:			
Hernia?	Yes ❑ No ❑	Loss of sexual function?	Yes ❑ No ❑
Prostate problems?	Yes ❑ No ❑	Other:	

Women:	
Are you still having monthly periods? Yes ❑ No ❑	Are they: Heavy ❑ Regular ❑ Painful ❑
Date of last period:	Bleeding between periods? Yes ❑ No ❑
Do you plan a pregnancy in the next two years? Yes ❑ No ❑	Method of birth control?
Date of last PAP test?	Date of last mammogram?
Number of pregnancies:	Number of live births:
History of Polycystic Ovary Syndrome Yes ❑ No ❑	Number of Caesarean sections:

Review of Systems: Musculoskeletal			
Do you have:			
Pain in calves while walking?	Yes ❑ No ❑	Cramps in legs at night?	Yes ❑ No ❑
Pain in big toe?	Yes ❑ No ❑	Joint pain or arthritis?	Yes ❑ No ❑
Back problems?	Yes ❑ No ❑	Difficulty ambulating/walking?	Yes ❑ No ❑
Describe difficulties:			

Sleep Apnea Screen.				
Do you snore?				
Have you ever been diagnosed with sleep apnea?				
Please indicate how likely you are to doze off or fall asleep during the following situations, in contrast to just feeling tired.				
	Would Not Doze	Slight Chance of Dozing	Moderate Chance	Likely to doze
Sitting and Reading				
Watching TV				
Sitting in a theater or a meeting				
As a passenger in a car for one hour without a break				
Lying down in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped a few minutes in traffic				
Total				

Pain Screening			
Are you currently experiencing any significant pain?			
Does pain Interfere with your daily activities?			
Does pain affect your quality of life?			
Have you sought out medical treatment for pain?			
Please list current pain medications below			
Medication	Dose	How Often	Pain Location

Statement of Limitations:
Describe the limitations (emotional, physical, employment) which morbid obesity imposes on you. **This section is required to complete the application—we will not process your chart without this having been filled out. Use a separate piece of paper if necessary.**

WEIGHT MANAGEMENT HISTORY			
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 as possible.			
	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 five years: 2008 _____ 2009 _____ 2010 _____ 2011 _____ 2012_____

Women—Weight retained after each pregnancy:	lbs./ year:	lbs./ year:	lbs./ year:	lbs./ year:

Medically supervised weight loss programs:

Doctors who have treated you	**Programs**	**Weight Lost**	**Weight Regained**	**Length of Program**	**Est. Cost**
	Optifast				
	Medifast				
	Xenical				
	Phen-Fen				
	Meridia				
	Phenteramine				
	Pondimin				
	Diabetes education				

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)						
Richard Simmons						
Slim Fast						
HMR						
Atkins						
The South Beach Diet						
TOPS						
LA Weight Loss						
Other						
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:

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, PHYCHIATRIC 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.

SIGNATURE: DATE:

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