Advanced Laparoscopic Surgeons

New Patient Intake Form

Please complete the following questionnaire and return it to our office via e-mail or fax prior to your appointment. Please answer all questions to the best of your ability. **For claims to be submitted to insurance, the entire 1st page must be completed.**

PATIENT INFORMATION		
Patient name:		☐Male ☐Female
Birth date:	Soc. Sec. no.:	Marital status: ☐S ☐M ☐D ☐W
Mailing address:		Apt no.:
City:	State:	Zip:
Home Phone:	Cell Phone :	
Cell Phone Carrier: ☐Altel ☐AT&T ☐Boost ☐Cricket ☐Sprint ☐TMobile ☐USCellular ☐Verizon ☐VirginMobile		
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 #:		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 #:		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:	

Advanced Laparoscopic Surgeons of Morris, LLC 83 Hanover Road, Suite 190, Florham Park, NJ 07932
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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:
Previous Surgeries / Procedures / Hospitalizations:	
1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:
6.	Date:

Previous Bariatric Surgery ☐ **Covered by Insurance- please provide copy of Authorization Letter**

Surgery	Surgeon	Date	Weight Lost	Weight Regained

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:**

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

Physicians: (Please provide a list of your current physicians)

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

Personal Habits

Do you smoke?	☐Yes ☐No		How Long_____	Year Quit_____
		How Much_____	☐Daily ☐Weekly ☐Monthly	
Do You drink Alcohol?	☐Yes ☐No	How Much_____	☐Daily ☐Weekly ☐Monthly	
Do you use drugs?	☐Yes ☐No	Type_____	☐Daily ☐Weekly ☐Monthly	
Have you ever used drugs?	☐Yes ☐No	Type_____		

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	☐ Overweight (20-99 lbs.)	☐ Obese (over 100 lbs)
☐ Tuberculosis	☐ Other (Explain)	

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Review of Systems: Neurologic			
Severe headaches?	☐Yes ☐No	Weakness in arms / legs?	☐Yes ☐No
Pain on one side of the head?	☐Yes ☐No	Visual Disturbances?	☐Yes ☐No
Do headaches awaken you at night?	☐Yes ☐No	Ringing in ears?	☐Yes ☐No
What relieves headaches?		Double vision?	☐Yes ☐No
Review of Systems: Cardio respiratory			
Have you had shortness of breath?			
Doing normal work?	☐Yes ☐No	Do you have bleeding problems?	☐Yes ☐No
Climbing flights of stairs?	☐Yes ☐No	Do you have palpitations?	☐Yes ☐No
Accompanied by wheezing?	☐Yes ☐No	Do you have swollen ankles?	☐Yes ☐No
Do you have a chronic cough?	☐Yes ☐No	Do you have phlebitis or inflamed leg veins?	☐Yes ☐No
Does it awaken you at night?	☐Yes ☐No	Do you have varicose veins?	☐Yes ☐No
Do you cough up sputum?	☐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
Does the chest pain:			
Radiate to the arm, neck or back?	☐Yes ☐No	Abate when you rest?	☐Yes ☐No
Review of Systems: Psychiatric			
Do you have a history of psychiatric illness?	☐Yes ☐No	Depression?	☐Yes ☐No
Anxiety?	☐Yes ☐No	Obsessive-compulsive disorder?	☐Yes ☐No
Suicide attempts?	☐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
Do you have:			
Abdominal cramps?	☐Yes ☐No	Alternating diarrhea and constipation?	☐Yes ☐No
Pain during or after bowel movements?	☐Yes ☐No	Black stools?	☐Yes ☐No
Review of Systems: Genitourinary			
Have you had:			
Dark-colored urine?	☐Yes ☐No	Blood in the urine?	☐Yes ☐No
Have you passed a kidney stone?	☐Yes ☐No	Trouble starting to urinate?	☐Yes ☐No
Frequency/awakening at night?	☐Yes ☐No		
Loss of bladder control / trouble holding urine / stress incontinence?			☐Yes ☐No
Review of Systems: Genitourinary- Male			
Hernia?	☐Yes ☐No	Loss of sexual function?	☐Yes ☐No
Prostate problems?	☐Yes ☐No	Other:	
Review of Systems: Genitourinary- Female			
Are you still having monthly periods?	☐Yes ☐No	Are they: Heavy ❑ Regular ❑ Painful ❑	
Method of birth control?		Bleeding between periods?	☐Yes ☐No
Date of last PAP test?		Do you plan a pregnancy in the next 2 years?	☐Yes ☐No
Number of pregnancies:		Date of last mammogram?	
Number of live births/ Caesarean sections:		History of Polycystic Ovary Syndrome	☐Yes ☐No

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Review of Systems: Musculoskeletal			
Do you have:			
Cramps in legs at night?	☐Yes ☐No	Pain in calves while walking?	☐Yes ☐No
Pain in big toe?	☐Yes ☐No	Heel, arch or Achilles pain?	☐Yes ☐No
Back problems?	☐Yes ☐No	Custom molded orthotics?	☐Yes ☐No
Joint pain or arthritis?	☐Yes ☐No	Acute of chronic itching of the feet?	☐Yes ☐No
Difficulty ambulating/walking?	☐Yes ☐No	Diabetes or poor circulation?	☐Yes ☐No
Describe difficulties:			

Sleep Apnea Screen			
Score 1 point for each "Yes" answer below:			
Do you snore?	☐Yes ☐No	Have you been diagnosed with sleep apnea?	☐Yes ☐No
Do you awaken from sleep gasping or short of breath?	☐Yes ☐No	Have you been told that you stop breathing during sleep?	☐Yes ☐No
Are you tired during the day?	☐Yes ☐No	Are you un-refreshed after a night's sleep?	☐Yes ☐No
Is your neck size >16" for a woman or >17" for a man?	☐Yes ☐No	Do you take 2 or more medications for hypertension?	☐Yes ☐No
		Are you newly diagnosed with hypertension?	☐Yes ☐No

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 =0	Slight Chance of Dozing=1	Moderate Chance=2	Likely to Doze=3
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				

A sleep study is indicated for a total score of ≥ 3

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Statement of Limitations:
Describe the limitations (emotional, physical, employment) which morbid obesity imposes on you. This information can assist our office in obtaining approval from your insurance company. 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:	**2011**	**2012**	**2013**	**2014**	**2015**

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				

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Other programs that you have attended: REQUIRED for Insurance Approval					
Program	**Year(s)**	**Weight Lost**	**Weight Regained**	**Length of Program**	**Est. Cost**
Weight Watchers					
Overeaters Anonymous					
Diet Centers					
NutriSystem					
Jenny Craig					
Medications (nonprescription)					
Richard Simmons					
Slim Fast					
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					
DVD/ Internet/ TV					
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 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 MY CARE (INCLUDING PRE-CERTIFICATION AND VERIFICATION, IF NECESSARY) OR THAT WHICH MAY BE NEEDED TO CONDUCT CONTINUED CARE PLANNING.

SIGNATURE **DATE:**

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