

**NEW PATIENT INFORMATION**

<b>Personal Information</b>					
Last Name:		First Name:		Gender: Male / Female	
Date of Birth:		Age:	Soc Sec #:	Marital Status: Single / Mar / Div / Sep / Wid	
Education: High School / Some College / Associate Degree / Bach degree / Master's / Ph. D					
Race: White / Black or African Am / Am Indian / Asian / Hispanic or Latino					
Mailing Address:				Apt #:	
City:		State:		Zip:	
Home Phone #:		Cell Phone #:		Email:	
Height: ____ ft. ____ in.		Weight: ____ lbs.		Allergies:	
<b>Employer Information</b>					
Occupation		Employer:		Work Phone #:	
Employer's Address:					
City:		State:		Zip:	
<b>Payment Information</b>					
Person responsible for the Bill:			Relationship to the patient:		
Address (if different):					
City:		State:		Zip:	
Home Phone # (if different):		Work Phone # (if different):		S.S. #:	
<b>In Case of Emergency</b>					
<i>Local Friend or Nearest Relative</i>					
Name / Relationship:			Home Phone #:		
			Work Phone #:		
<b>How did you find out about us?</b>					
1. Physician referral _____ 2. Friends _____ 3. Family _____ 4. Our Patient _____ 5. Newspaper _____ 6. Magazine _____			7. T.V. _____ 8. Radio _____ 9. Internet _____ 10. Obesityhelp _____ 11. Google _____ 12. Other _____		

**NEW PATIENT INFORMATION**

<b>Primary Insurance Information</b> <i>Please give your insurance card &amp; ID to the receptionist</i>		
Insurance Carrier:	Phone #:	
Policy #:	Group #:	
Subscriber's Name:	Subscriber's S.S. #:	
Insured's Mailing Address:		
City:	State:	Zip:
Insured's Employer:	Work Phone #:	
Patient's Relationship to Subscriber: self / spouse / child / other _____		
<b>Secondary Insurance Information</b> <i>Please give your insurance card &amp; ID to the receptionist</i>		
Insurance Carrier:	Phone #:	
Policy #:	Group #:	
Subscriber's Name:	Subscriber's S.S. #:	
Insured's Mailing Address:		
City:	State:	Zip:
Insured's Employer:	Work Phone #:	
Patient's Relationship to Subscriber: self / spouse / child / other _____		
<b>Insurance Authorization</b>		
<p>I authorize the release of medical information necessary to process the insurance claim(s). I authorize and direct my insurance carrier or intermediaries to issue payment check(s) directly to New Jersey Bariatric Center Or Physicians who rendered services at the office.</p> <p>I understand that my insurance company may require an authorization number, precertification and/or referral. Without this documentation, I understand that my insurance company may deny benefits. If my insurance company denies payment for service(s) rendered by New Jersey Bariatric Center or physicians who rendered services at the office, I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF THE SERVICES RENDERED. I understand that I am responsible for any amount not covered by my insurance such as but not limited to deductible and co-insurance. I further understand that New Jersey Bariatric Center cannot accept responsibility for collection of my claim(s) or for negotiating a settlement on a disputed claim once your claim goes to a collection company for non-payment.</p>		
Print Name: _____ Date: ___/___/___		
Signature: _____		

**NEW PATIENT INFORMATION**

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Please Print Your Name	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date of Birth	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Social Security Number
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**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ANSWER ALL THE QUESTIONS.**

This Notice of Privacy Procedures describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

**TREATMENT:**

We will use your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you, and/or to review your health information with a case manager who is coordinating your care.

**PAYMENT:**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**HEALTHCARE OPERATIONS (TPO):**

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting/arranging for other business activities. For example, we may disclose your protected health information to:

- Medical school students that see patients at our office.
- We may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

## NEW PATIENT INFORMATION

- With your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

- As Required By Law
- Public Health issues as required by law – communicable diseases, health oversight, abuse or neglect
- Food and Drug Administration requirements
- Legal proceedings
- Law enforcement, Criminal activity, Inmates
- Coroners, Funeral Directors and Organ Donation
- Research
- Military Activity, National Security
- Workers' Compensation

Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **YOUR RIGHTS:**

Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and receive a copy of your protected health information. Under federal law, however, you may not inspect or copy Psychotherapy notes,
- Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;
- Protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Procedures. Your request must state the specific restriction(s) requested and to whom you want the restriction(s) to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice, upon request.

**NEW PATIENT INFORMATION**

- You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying any supervisor, a member of our administration, or our designated Privacy Officer.

This notice was published and becomes effective April 14<sup>th</sup>, 2003.

We are required by law to maintain the privacy of , and provide individuals with, this notice of our legal duties and privacy procedures with respect to your protected health information. If you have any objections to this form, please notify our Administration at (908)378-1779.

Please answer the questions below and affix your signature acknowledging that you received this Notice of you Privacy Policy and Procedures and have provided specific direction and authorization in protecting your health information.

- Who may we provide with your personal health information? Check all that apply and give phone #.  
 Spouse      Children      Parent      Other, specify \_\_\_\_\_  
\_\_\_\_\_
- May we leave personal health information on your answering machine at home?  
 YES                       NO

Patient's Signature	(Print) Patient's Name	Today's Date
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**NEW PATIENT INFORMATION**

<b>Last Name:</b>	<b>First Name:</b>	<b>Age</b>
<b>Referral Information</b>		
<b>Primary Care Doctor (NAME):</b>		
Address/City/State/Zip		Phone
<b>Referring Doctor if other than primary care physician (NAME):</b>		
Address/City/State/Zip		Phone
<b>Psychologist (NAME):</b>		
Address/City/State/Zip		Phone
<b>Nutritionist (NAME):</b>		
Address/City/State/Zip		Phone
<b>Gastroenterologist (NAME):</b>		
Address/City/State/Zip		Phone
<b>Gynecologist (NAME):</b>		
Address/City/State/Zip		Phone
<b>Cardiologist (NAME):</b>		
Address/City/State/Zip		Phone
<b>Other (NAME):</b>		
Address/City/State/Zip		Phone
<b>Other (NAME):</b>		
Address/City/State/Zip		Phone

**NEW PATIENT INFORMATION**

<b>Last Name:</b>	<b>First Name:</b>	<b>Date:</b>
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<b>WEIGHT RELATED ILLNESS</b>	<b>YES</b>	<b>NO</b>
<b>1. Heart Disease:</b>		
a) Do you wake up out of breath at night?		
c) Do you sleep upright in bed?		
e) Do you have chest pain with exercise?		
g) Do you have varicose veins?		
i) Do you have shortness of breath after climbing one flight of stairs?		
j) How many blocks can you walk without having to stop for breath?		
b) Do you have Angina?		
d) Have you had a Heart Attack?		
f) Do you get leg cramps when you walk?		
h) Are you bothered by palpitations?		
<b>2. High Cholesterol Level:</b>		
<b>3. Diabetes:</b> controlled with diet, pills or insulin?		
<b>4. High Blood Pressure:</b>		
<b>5. History of Stroke:</b>		
<b>6. Joint Pain:</b>		
a) Hip Pain?		
c) Foot/Ankle Pain?		
e) Back Pain?		
b) Knee Pain?		
d) Foot/ Leg Swelling?		
<b>7. Sleep Apnea Syndrome:</b>		
a) CPAP used <i>setting</i>		
b) Morning headache?		
c) Do you have Morning Fatigue?		
d. Restless sleep?		
e) Do you snore at night?		
f) Do you fall asleep during the day?		

**NEW PATIENT INFORMATION**

<b>WEIGHT RELATED ILLNESS -- Answer Yes or No</b>	<b>YES</b>	<b>NO</b>
<b>8. Asthma:</b>		
a) ER visit in the last 2 years?		
b) Hospitalization in the last 2 years?		
<b>9. Gastrointestinal:</b>		
a) Do you have Heart Burn?		
c) Belching of sour fluid?		
e) Colitis/Irritable Bowel?		
g) Any history of Abdominal Pain?		
i) Hiatal hernia?		
b) Do you have difficulty Swallowing?		
d) Coughing or choking at night?		
f) Constipation or diarrhea?		
h) Ultrasound of gall-bladder?		
j) Hepatitis?		
<b>10. PSYCHOLOGY: I often have...</b>		
a) Anxiety/Nervousness?		
b) Alcohol abuse?		
c) Panic attacks or disorder?		
d) Thoughts of Suicide?		
e) Depression (moderate-severe)?		
f) Bipolar disorder		
g) Obsessive compulsive disorder		
<b>Hospitalization:</b> when _____ Condition _____		
<b>Psychotherapy:</b> when _____ Condition _____		
<b>Have you had thoughts of Suicide?</b>		
<b>11. HEMATOLOGY/ONCOLOGY:</b>		
a) Cancer (what type)?		
b) Easy bruising?		
c) History of blood clots in your arms, legs, or lungs?		
d) Anemia?		

**NEW PATIENT INFORMATION**

e) Cold or Heat intolerance?		
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**NEW PATIENT INFORMATION**

<b>WEIGHT RELATED ILLNESS -- Answer Yes or No</b>	<b>YES</b>	<b>NO</b>
<b>12. GENITOURINARY TRACT:</b>		
a) Trouble starting urine?		
b) Do you sometimes lose control of urine?		
c) Number of times you urinate at night? _____ #		
d) Number of times you urinate during the day? _____ #		
<b>13. NEUROLOGIC:</b>		
a) Have you ever fainted?		
b) Have you ever had a convulsion?		
c) Have you ever had a Seizure		
<b>14. GYN Problems FOR WOMEN ONLY</b>		
a) Any <b>heavy</b> period?		
b) Any <b>painful</b> periods?		
c) Date of last <b>mammogram</b> ?		
d) Are you <b>pregnant now</b> ?		
e) Do you have <b>excess body hair</b> or acne?		
f) Has your doctor told you that you have <b>polycystic ovaries</b> ?		
g) Date of last menstrual period? _____ (month/year)		
h) Do you take birth control pills?		
i) Any <b>Irregular</b> period?		
j) Date of last <b>PAP</b> smear?		
k) Have you had hot flashes?		
l) Do you have problems with <b>infertility</b> ?		

**NEW PATIENT INFORMATION**

<b>PAST MEDICAL HISTORY/ SURGICAL HISTORY</b>			
<b>Current Medications – list daily medications as well as those used as needed</b>			
<b>Medication</b>	<b>Dosage</b>	<b>How often?</b>	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
<b>Have you been prescribed weight loss medications?</b>			
<b>Medication</b>	<b>Duration</b>	<b>Weight loss</b>	<b>Reason for stopping</b>
1.			
2.			
3.			
<b>Previous Surgeries / Procedures:</b>			
<b>Surgical Procedure</b>	<b>Date</b>	<b>Surgical Procedure</b>	<b>Date</b>
1.		4.	
2.		5.	
3.		6.	
<b>Hospitalization – list diseases which have required hospitalization</b>			
<b>Problem</b>	<b>Date</b>	<b>Problem</b>	<b>Date</b>
1.		4.	
2.		5.	
3.		6.	
<b>Personal Habits:</b>			
Do you smoke?		How many packs per week?	
When did you quite smoking?			
Do you drink alcohol?		How much?	
Do you use drugs?		What kind/ how much?	
Have you ever used drugs?			

**NEW PATIENT INFORMATION**

<b>FAMILY HISTORY</b>					
<i>Please specify who in your family has the specified medical problem?</i>					
	<b>Mother</b>	<b>Father</b>	<b>Brother</b>	<b>Sister</b>	
a. Obese (over 100lbs.)					
b. Heart Disease					
c. Diabetes					
d. High blood pressure					
e. Stroke					
f. Sleep Apnea					
g. Bleeding Problems					
h. Cancer (Specify)					
i. Overweight (20 – 99lbs)					
j. Other					

<b>Pulmonary - Sleep Apnea test</b>		
I have been told that I snore or know that I snore. (+20)		
I definitely do not snore. (-50)		
I do not know if I snore. (0)		
I have been told that I stop breathing when I sleep. (+10)		
I wake up choking. (+10)		
My neck circumference is more than 17inches. (+20)		
I frequently have morning headaches. (+5)		
I am a restless sleeper (toss and turn a lot). (+5)		
I sweat excessively at night. (+5)		
I wake up tired and un-rested (+2)		
I have fallen asleep while driving (5)		
I suddenly wake up unable to breath (10)		
I am tired and sleepy during the day even after 8 hours of sleep (2)		
<b>TOTAL</b>		

**NEW PATIENT INFORMATION**

**WEIGHT LOSS HISTORY**

*Insurance companies request the period you have been engaged in attempts to lose weight and professionals you may have consulted?*

**DIETARY HISTORY**

Programs	Year	Weight Lost	Weight Regained	Length of Program	Est. Cost
Weight Watchers					
Richard Simmons					
LA Diet					
Slimfast					
Jenny Craig					
The Zone					
Trimspa					
Nutrisystem					
SugarBusters					
The Blood Type					
Dr.Weil's Diet					
Atkin's Diet					
Health Spas					
Gym/Exercise program					
South Beach Diet					
Acupuncture					
Other:					

**WEIGHT HISTORY**

*Please estimate as closely for all that applies.*

Life Event	Age	Weight (in lbs)
Start of High School		
Weight at Age 18	18	
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		
Largest Weight Loss		

**NEW PATIENT INFORMATION**

Years you have been morbidly obese (over 100lbs)? _____years					
<b>Medically supervised weight loss programs:</b>					
Programs	Doctors who treated you?	Weight Lost	Weight Regained	Length of Program	Est. Cost
Optifast					
Xenical					
Phen-Fen					
Meridia					
Diabetes Education					

<b>EXERCISE HISTORY</b>
Are you presently participating in a regular exercise program (3-4 times per week, 30 minutes per session)? If yes, please describe.
Have you in the last 5 years participated in a regular exercise program? If yes, Describe.
Are you limited during exercise by shortness of breath, dizziness or chest discomfort? If yes, please specify.
Are you limited during exercise by joint pain or swelling, muscle pain, back pain, torn ligaments? If yes, please describe.

**NEW PATIENT INFORMATION**

<b>CONCERNS</b>
How much weight loss are you expecting after surgery for weight reduction?
How does your family feel about you having this surgery? Supportive? Not Supportive?
What are your concerns or fears about the surgery?
What are your concerns about your own health?

<b>FOOD HISTORY</b>												
1. 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.												
<table border="0"> <tr> <td>___ Candy</td> <td>___ Ice cream</td> <td>___ Cake/pies</td> <td>___ Steaks/chops</td> </tr> <tr> <td>___ Pizza</td> <td>___ Potatoes</td> <td>___ Fried foods</td> <td>___ Salad dressing</td> </tr> <tr> <td>___ Cookies</td> <td>___ French fries</td> <td></td> <td></td> </tr> </table>	___ Candy	___ Ice cream	___ Cake/pies	___ Steaks/chops	___ Pizza	___ Potatoes	___ Fried foods	___ Salad dressing	___ Cookies	___ French fries		
___ Candy	___ Ice cream	___ Cake/pies	___ Steaks/chops									
___ Pizza	___ Potatoes	___ Fried foods	___ Salad dressing									
___ Cookies	___ French fries											
2. How many times per week do you eat out: 1 2 3 4 5 6 7 or more												
3. Are you a large volume eater at mealtimes with minimal snacking? YES / NO												
4. How do you react to stress? eating / snacks / exercising / sleeping												
5. Name your top three favorite foods? 1. _____ 2. _____ 3. _____												
6. How long after eating your last meal, do you go to sleep? _____ hours												
7. Have you had a successful weight loss in the past? YES / NO a. If YES, How much _____ lbs and over how long did it take you _____.												
8. Are you dependent on anti-inflammatory agents such as Advil, Motrin etc.? YES / NO												
9. How many meals do you eat per day 2 3 4 5 6												
10. How often do you snack 1 2 3 4 5 6												

<b>Please attach recent photo of yourself, and indicate the date in which they were taken: (Include front, side and back views with clothes)</b>	
<b>Weight:</b>	<b>Waist size:</b>
<b>Height:</b>	<b>Hip Size:</b>
<b>Target Weight:</b>	<b>Abdominal size:</b>
<b>BMI:</b>	

**HOME-WORK**

<b>Please make copies of this page and fill it out a two week period so we can analyze your food intake</b>	
<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	
<b>Other foods</b>	