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Jonathan Reich M.D., F.A.C.S
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Richard Greco, DO
James Nangeroni, DO
Marius Calin, M.D.

NJ Weight Loss Doctors
Specialists in Weight Loss Surgery

Patient Information Sheet

Seminar:	Office Visit:		Surgical Date:	**RNY/BAND/SLEEVE**
Name: Nombre:			Primary Physician: Medico Primario:	
Address: Direccion:			Physician Phone: Telefono Medico:	
City, Zipcode: Cuidad, Zipcode:			Physician Fax:	
Preferred Phone # Numero Preferrido			Alternate Phone # Nuemero Alternativo	
DOB: Fecha de nacimiento:	Age: Edad:	Sex: M / F Sexo:	Marital Status: Estado Matrimonial:	SS# Seguro Social -
Email Address: Coreo Electronico:				
Occupation: Occupacion:		Employer: Empleado:		Business Phone: Telefono:
Primary Ins. Co: Seguro Primario:			Secondary Ins. Co: Seguro Secondario:	
Policy #: Polisa de seguro:			Policy #: Polisa de seguro:	

CONSULTS – FOR OFFICE USE

Cardio	
Pulmonary	
GI	
Psych	
Nutrition	
PCP / Other	

Please sign required signature line – We will discuss with you if any questions

Solo para pacientes de Medicare / Medicare Patients Only: "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Stafford Surgical Specialists / Monmouth Surgical Specialists / Montclair Surgical Associates (SSS/MSS/MSA) for any services rendered to me by the physicians of SSS/MSS/MSA. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

Signature / Firma _____Date / Fecha _____

Pacientes que no son de Medicare / Non-Medicare Patients: I request that payment of authorized benefits be made either to me or on my behalf to Stafford Surgical Specialists / Monmouth Surgical Specialists / Montclair Surgical Associates (SSS/MSS/MSA) for any services rendered to me by the physicians of SSS/MSS/MSA. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits of the benefits payable for related services.

Signature / Firma _____Date / Fecha _____

Surgical Assistant Policy / Cirujano Asistente

Only the operating surgeon can decide if an assistant surgeon is required for the proper conduct of an operation. Some insurance plans do not cover the services of an assistant surgeon, even when requested by the operating surgeon with the patient's best interest and safety in mind. Please be advised that in such cases you will be billed directly for the assistant's services. The usual and customary fee for the assistant is 25% of the surgeon's fee. We are happy to discuss this policy with you if there are any questions. Your signature affirms that you have read this policy.

Signature / Firma _____Date / Fecha _____

Medication Log and Co-Morbidity
Lista de Medicamentos

Patient's Name:_____ **DOB:**_____

ALLERGIES: Alergias				
List of Medications: ******Please Include Over the Counter Medications******				
Name: Nombre	Dose Dosis	Frequency Frequencia	Duration	Reason for Taking
☐ **NSAID warning given**				
Sleep Apnea- Apnea de sueno	☐ CPAP		☐ BiPAP	
Oxygen- Oxigeno	☐ 24 hours		☐ During Sleep	

****** Please review list. Write current date and your initials.******

OFFICE USE ONLY: List of Co-Morbidities:

Revised 6/19

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Acknowledgement of HIPAA privacy notice and designation of disclosure

Privacidad

Patient Name: _____ Date of Birth:_____
I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication
Home/Cell Telephone Number:

_____
___Ok to leave a message with detailed information – **Dejar mensaje**

Written Communication:
__Ok to mail to my home address that I listed on registration.- **Enviar por correo**

Other:_____

Designation of Certain Relatives, Close Friends and Other Caregivers: **Familia/amistad**

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of practice making limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____
Print Name:_____ Relationship:_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the Physician's Practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as: *A basis for planning my care and treatment. *A means of communication among the many health professionals who contribute to my care. *A source of information for applying my diagnosis and surgical information to my bill. *A means by which a third-party payer can verify that services billed were actually provided, and I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent.

I understand that the Physician's Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Physician's Practice reserves the right to change their notice and practices prior to implementation, in accordance with Section 164-520 of the Code of Federal Regulations. I wish to have the following restrictions to the use or disclosure of my health information.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** (**circle one**) the terms of this consent.
I have been presented with and understand the Physician's Practice Notice of Privacy Policy.

Email Address _____ ☐ Check box if ok to use email as a method of contact

Signature of Patient/Parent/Guardian:_____Date: _____

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Date_____ Pre-Op Patient Assessment Questionnaire

Name		Last		
DOB	Age	☐Female ☐Male		
☐Gastric Bypass ☐LapBand ☐ Sleeve ☐Don't Know				
Allergies /Reaction:				
Medications you are currently taking: See attached Medication Log				
Do you have:				
☐Arthritis - Artritis	☐Fibroids - Fribroma	☐Joint pain or swelling		
☐Angina - Angina	☐GERD reflux disease – Gastroesofagio	☐Lupus-		
☐Asthma	☐Gallbladder disease-Vesicula biliar	☐Ovarian Cysts-quiste ovario		
☐Blood Clots- Coagulo Sangre	☐Glaucoma	☐Peptic Ulcer Disease		
☐Bleeding Problems Problemas de sangrar	☐Hypertension - Hipertension	☐Stroke-Cerebrovasvular		
☐BPH, prostate disease	☐Heart Attack – Ataque Cardiotico	☐Shortness of Breath		
☐Congestive Heart Failure Cardiaca Congestiva	☐High Cholesterol (>200) - Colesterol	☐Sleep Apnea- Sueno Apnea		
☐Coronary Disease-	☐Hypoventilation Syndrome (pCO2>45 or hemoglobin)	☐CPAP ☐BIPAP		
☐Colitis	☐Hypothyroid-Hipotiroidismo	☐Snoring-ronquidos		
☐Cataracts	☐Hepatitis	☐Skin Disease		
☐Cancer Tumors If yes, what type	☐Idiopathic Intracranial Hypertension Pseudotumor Cerebri	☐ Sexually transmitted disease When _____ Type _____		
☐Diabetes	☐Infertility - Esterilidad			
☐Diverticulitis	☐Incontinence bladder/bowel	☐Venous Stasis		
☐Depression	☐Irregular Periods/Last period:	☐Other		
☐Emphysema	If post-menopausal, since what date:			

Please List all prior surgeries/hospitalizations/injuries – *Lista de Operaciones*

Operation	Date	Hospital	Surgeon	Any problems

Did you have general anesthesia? ☐No ☐Yes	Problems? Con anesthesia ☐No ☐Yes

Family history Check family members who have had any of the following problems

Obesity- Obesidad	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Brother	Sister	Other
Heart Disease								
Stroke								
Diabetes								
High Blood Pressure								
Sleep Apnea								
Bleeding								
Cancer								

Social History

Do you smoke? ☐No ☐Yes – If Yes, how much? Packs per day. -Fuma	
Do you drink alcohol?- ☐No ☐Yes – If Yes, how much?	How long ago did you quit?
Do you use recreational drugs?- Usa drogas ☐No ☐Yes – If Yes, what type and how much?	
What kind of work do you do?	
Do you plan a pregnancy in the next two years? ☐No ☐Yes	

To what degree do you feel that weight affects your life (1=minimal affect, 5=severe)

	1	2	3	4	5	Comments
Self Esteem- Autoestima						
Physical Activity- Actividad						
Socially Involved- eres sociable						
Able to Work- trabajar						
Interested in Sex- sexo						
Financial Well Being						
Participates in Recreation						

Please answer the following regarding your attempts to lose weight

How long have you been over weight? Cuanto tiempo estas sobre peso?	What was your weight at age 18? Cuanto pesavas cuando tenia 18 anos?
Lowest adult weight in the past 5 years En 5 anos cuanto tenia bajo peso?	Highest adult weight in the past 5 years Mas peso alto en 5 anos?
What was the biggest loss in pounds you had? Cuanto peso perdiste bastante?	How long did it take you to lose the weight? Cuanto tiempo te tomastes?
Did you regain this weight ☐No ☐Yes	How long did it take you to regain the weight?

What kind of exercise are you doing currently? Ejercisios?

☐Treadmill- rueda de andar	☐Jogging - Correr
☐Walking - Camina	☐Personal Trainer- Entrenador Privado
☐Swimming- Nadas	☐Aerobics

☐Wt. Training- usas pesas	☐VHS/DVD
☐Bicycle- Bicicleta	☐Other

How were you referred to the Center for Bariatrics?	
Physician:	Previous Patient:
Friend/Family Member:	Newspaper Ad:
TV/Radio:	Internet/Website:
Other:	Other:

	Name	Phone	Fax	Town
Primary MD				
Gastro				
Cardiac				
Pulmonary				
Endocrine				
Psych				
Dietitian				
OB/GYN				

Patient Name _____Pre-Op Patient Assessment Questionnaire

Weight Loss History – que has hecho para perder peso				
Insurance companies request the following information.				
Programs	Dates (mm/yyyy)	Duration	MD Supervised	Amount of Weight Loss
Weight Watchers				
Keto				
Whole 30				
Slimfast				
Jenny Craig				
Intermittent fasting				
Nutrisystem				
Optifast				

Isogenix				
Mediterranean				
DASH				
Atkin's Diet				
South Beach Diet				
Health Spas				
Gym/Exercise Program				
Contrave				
Saxenda				
Medication - Non prescribed				
Weight Loss Medication Medicamento para perder peso				
Medically Supervised Diets				
Others				

If you have surgery. How much weight do you expect to lose? Cuanto crees perder con la surugia?

Did you attend our weight loss seminar? If yes, when?