Patient Name_____

HonorHealth Bariatric Center

Mail completed packet to:
10210 North 92nd Street, Suite 101
Scottsdale, Arizona 85258
Phone: 480-882-7460
Fax: 480-391-3898

Or email to:
weightloss@honorhealth.com

Seminars are available online
Visit **Honorhealth.com/bariatrics** to register.

Patient Name_____

Congratulations!
By considering the option to undergo weight loss surgery, you have taken the first step necessary to change your health...and your life. Please read the following information carefully.

Please do not print the packet double sided.

Steps in the Process:

1. **You must attend our educational seminars. Honorhealth.com/bariatrics**

2. **Confirm your insurance coverage for weight loss surgery.**

Patients Paying Cash:

Patients who have decided to pay cash because they have no insurance benefit go directly to #3 below.

If you are going to use insurance to pay for your surgery:
Contact your insurance carrier to determine whether you have a weight loss benefit as part of your insurance coverage.
Your insurance company may require a medically supervised weight loss program. You may opt to work within our system of care or with your primary care physician to complete your supervised weight-loss program.

3. **Complete and submit your new patient packet.**
You must **completely fill out** your new patient packet and **sign it** in order for us to determine whether you're a candidate for surgery at the HonorHealth Bariatric Center. **Please complete this packet in ink or typed.**
   - Include a **copy** (front and back) of your **insurance card** with your completed packet.

4. **Support documentation is now required** by all insurance companies for HMO, POS and PPO type plans. You will need to provide:
   - A letter from a physician supporting your decision to undergo weight loss surgery.
   - The physician will refer to this as a letter of medical necessity. We have attached a copy of a sample letter that you can give to your primary care doctor to complete.
   - If your insurance company requires a supervised medical weight loss period, we can help by having you work with our medical weight loss specialist.
   - This program is covered by most insurance plans.

5. **Submitting your completed packet:**
   i. You can bring the packet, insurance information and supporting documentation to our office or,

ii. **Mail** your completed packet and documentation to:

HonorHealth Bariatric Center
10210 North 92nd Street, Suite 101
Scottsdale, Arizona 85258

iii. **Fax** to: 480-391-3898

iv. Or **Email** your completed packet and documentation to:
weightloss@honorhealth.com

6. **When we have received your packet:**

- **We will verify your insurance benefit, co-pay and eligibility requirements. Our patient liaison will then call you to answer any questions you may have and help you develop a plan to complete the program. (Please allow 14-21 business days for this)**
- For patients who are not using insurance to pay for the surgery, our patient liaison will call you to schedule your initial consultation and answer any remaining questions you may have.
- All patient packets are evaluated for possible medical problems or special situations that might require a different pathway of care.

7. **Your initial consultation will include:**
   - A comprehensive health history and physical evaluation by the surgeon.
   - A nutritional evaluation by one of our staff Registered Dietitians.
   - An exercise consultation by one of our staff Exercise Physiologist.
   - Your initial appointment at HonorHealth Bariatric Center will last approximately 2 hours.
   - All patients must complete a comprehensive psychological evaluation and testing by a Licensed Clinical Psychologist specializing in Bariatric surgery prior to surgery (not done the same day as consultation)
     - If you do not wish to see our in-house psychologist or unable to per your insurance guidelines, you will be given a list of psychologists that we work with in order to complete this requirement.
     -

PLEASE REMEMBER: Your insurance may require additional testing and clearances in order to authorize your Bariatric surgery.

AUTHORIZATION for surgery cannot be submitted without these documents.

*That's it! You're now on your way to better health. While it's understandable that you may be anxious to schedule this life-changing event, we **thank you for your patience** during the process.*
At HonorHealth Bariatric Center, we take every precaution to ensure your health, safety and long-term success.

Patient Name_____

HONORHEALTH

New Patient Registration Form – Demographics and Insurance

Height:_____Current Weight:_____

Patient: Name: First_____Middle_____Last_____

Aliases (other names you may go by):_____

SSN: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Patient street address and number:_____

Patient address additional: _____

City:_____State:_____ZIP:_____ _____

Primary Phone Number:_____ ☐ Mobile ☐ Home ☐ Work

Secondary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Email address: _____

What is your preferred language?_____Interpreter Required? ☐ Yes ☐ No

Are you Hearing impaired? ☐ Yes ☐ No Are you visually impaired? ☐ Yes ☐ No

Marital Status:

☐ Divorced ☐ Legally Separated ☐ Married ☐ Other ☐ Sig. Other ☐ Single ☐ Widowed

Religious preference:_____ ☐ I prefer to not answer

Mother's Maiden Name:_____ ☐ I prefer to not answer

The government requires that we ask the following 2 questions:

1) How do you identify your ethnicity?

☐ Hispanic or Latino, ☐ Not Hispanic or Latino,

☐ I prefer to not answer.

2) How do you identify your race?

☐ American Indian or Alaska Native ☐ Black or African American

☐ Native Hawaiian ☐ White or Caucasian ☐ Asian

☐ Other Pacific Islander ☐ I prefer to not answer

Who is your Primary Care Physician? _____

Contact information of the Primary Care Practice:_____

_____

_____

Phone #:_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed

Employer Name:_____ Occupation: _____

Patient Name_____

How many employees work at your company?
☐ 1-19 ☐ 20-99 ☐ 100+ ☐ Don't know

Who would you like to list as an emergency contact?
Name: _____
Address:_____
Relationship to you:_____
Phone Number: _____ ☐ Mobile ☐ Home ☐ Work

Who is the **guarantor** of your account? (Who is financially responsible for any amount not paid by the insurance company?) Please write "self" if it is you.

Guarantor: Name: First_____Middle_____Last_____
SSN:_____Date of Birth:_____Sex: ☐ M ☐ F
Address: _____
Phone Number:_____ ☐ Mobile ☐ Home ☐ Work

Primary Insurance:

Medical Insurance Company Name:_____
Member/Subscriber Identification #:_____Group #: _____
Medical InsuranceCompany Address: _____
Medical Insurance Customer Service Phone #: _____
Relationship of the insurance subscriber to the patient:
☐ Self ☐ Parent ☐ Spouse ☐ Other: _____
Subscriber: Name: First_____Middle_____Last_____
SSN:_____Date of Birth:_____ Sex: ☐ M ☐ F
Address: _____
Phone Number:_____ ☐ Mobile ☐ Home ☐ Work
Employer Name: _____
Occupation:_____
How many employees work at your company?
☐ 1-19 ☐ 20-99 ☐ 100+ ☐ Don't know
Do you have any additional insurance? ☐ Yes ☐ No

Secondary Insurance:

Medical Insurance Company Name:_____
Member/Subscriber Identification #:_____Group #:_____
Medical Insurance Company Address:_____
Medical Insurance Customer Service Phone #: _____
Relationship of the insurance subscriber to the patient:
☐ Self ☐ Parent ☐ Spouse ☐ Other:_____
Subscriber: Name: First_____Middle_____Last_____

Patient Name_____

SSN:_____Date of Birth:_____ Sex: ☐ M ☐ F

Address: _____

Phone Number:_____ ☐ Mobile ☐ Home ☐ Work

Employer Name: _____

Occupation:_____

How many employees work at your company?

☐ 1-19 ☐ 20-99 ☐ 100+ ☐ Don't know

Please present all insurance cards for copying.

How did you hear about HonorHealth Bariatric Center?

☐ Electronic Newspaper
☐ Family/Friend
☐ Magazine
☐ Newspaper
☐ Other _____
☐ Physician referral
☐ Radio
☐ Search Engine
☐ T.V.
☐ Website

Have you viewed a HonorHealth Bariatric Center Informational Seminar?

☐ No
☐ Yes
Date viewed: _____

Have you had a previous bariatric surgery or procedure? ☐ Yes ☐ No

Type of Surgery: _____ Date/place performed: _____

Current Complications(EX: reflux, nausea, vomiting) with surgery? _____

What procedure are you interested in?

☐ Bypass ☐ Sleeve ☐ Explant ☐ Hernia ☐ Revision (sleeve to bypass)
☐ Gallbladder ☐ Non Surgical Weight Loss _____
☐ Follow up Care ☐ Obesity Medicine Program (weight loss meds)

Clinical Study Participation:

HonorHealth Bariatric Center strives to provide our patients with various methods of achieving weight loss and is currently participating in clinical trials of new devices being tested for use in overweight/obese patients. If you are interested in participating in one of these clinical trials or want to discuss participation, check this box.

☐ Yes, I am interested in learning more about the clinical studies being performed at HonorHealth Bariatric Center.

☐ No, I am not interested at this time.

□ Have you or are you currently participating in a clinical trial? ☐ Yes ☐ No

Patient Name_____

Please fill out if you are over the age of 65 or on Medicare Disability only

Please check box **ONLY** if the answer is **"YES"**

☐ Are you receiving Black Lung Benefits?

☐ Are the services to be paid by a government research program?

☐ Are you entitled to benefits through the Dept of Veterans Affairs?

☐ Was the illness/injury due to a work-related accident/condition?

- Date of Accident:_____Location:_____Time: _____

☐ Has the illness/injury due to a non-work-related accident?

- Date of Accident:_____Location:_____ Time:_____

☐ Are you entitled to Medicare based on End Stage Renal Disease?

- Transplant Received?_____Dialysis tx?_____Dates_____

☐ Are you currently employed? If yes, place of employment_____

- Employer coverage?_____Plan:_____

☐ Do you have a spouse who is currently employed?

Retirement Dates (if applicable) or last date employed_____

☐ Never worked ☐ Yes ☐ No

Patient Name_____

New Patient Registration Form – Medical Information

Who are your current medical providers?	
Name	Specialty, or condition for which they treat you
Contact information for your pharmacy:	Name:
Phone #	Cross Streets:

Preventive Care					
Test	Year	Test	Year	Test	Year
Annual Physical		Prostate Screen		Cholesterol Test	
Colonoscopy		Pap Screen		Diabetes Screen	
Bone Density		Mammogram		Eye Exam	
Dental Exam					

Allergies or intolerances to medications?	
Name	Reaction

Please list all medications, supplements, over the counter drugs, creams and inhalers.			
Name	Dose/Strength	Frequency Taken	Reason for taking

**** Patients using Methadone for any purpose must be completely weaned off and engaged in a formal substance abuse rehabilitation program with documentation prior to scheduling a consultation****

Patient Name_____

Weight Related Illnesses

Have you had, or do you have, any of the following illnesses or symptoms?

1. **Heart Disease** ☐ Yes ☐ No Year diagnosed _____
   (Check all that apply to you)
   Taking medications for heart disease [Check all that apply: ☐ ASA ☐ Coumadin ☐ Plavix]
   ☐ Angina ☐ M.I. (myocardial infarction)
   ☐ Abnormal EKG ☐ CABG (coronary artery bypass graft)
   ☐ Palpitations ☐ Stress test to rule out cardiac problems
   *Provider: _____
2. **High Cholesterol** ☐ Yes ☐ No Year diagnosed _____
   (Check all that apply to you)
   ☐ High triglycerides ☐ Taking medication for high cholesterol
3. **High Blood Pressure** ☐ Yes ☐ No Year diagnosed _____
   ☐ Taking medications for high blood pressure
   Average pressure: _____
   List dietary restrictions: _____
4. **Pre-Diabetes** ☐ Yes ☐ No Year diagnosed _____
   ☐ Taking medications for pre-diabetes
5. **Diabetes** ☐ Yes ☐ No Year diagnosed: _____
   How Diagnosed? ☐ FBG ☐ HgA1c ☐ Glucola Test
   What type? ☐ Type I ☐ Type II ☐ Don't know
   Gestational ..... ☐ Yes ☐ No
   Controlled with ..... ☐ Diet ☐ Oral Medications ☐ Insulin
   Last fasting blood sugar: _____ Date: _____
   Last HgA1c: _____ Date: _____ Complications of T2DM:

   ☐ Neuropathy ☐ Kidney Disease ☐ Vascular Disease ☐ Amputation
6. **Asthma** ☐ Yes ☐ No Year diagnosed _____
   ☐ Taking medications for asthma
   ER visits in the last 2 years: _____
   Hospitalizations in last 2 years: _____
   Steroids used in last 2 years ☐ Yes ☐ No
7. **Reactive Airway Disease (RAD)** ☐ Yes ☐ No Year diagnosed _____
   Age at diagnosis _____ Taking medications for RAD
   What exacerbates RAD? _____
   Take which inhaler for RAD? _____
   Take which steroids for RAD? _____

Patient Name_____

8. **Sleep Apnea Syndrome**
(Check all that apply to you regardless if you have been diagnosed with sleep apnea or not)
Morning headaches ☐ Yes ☐ No
Daytime drowsiness ☐ Yes ☐ No
Restless sleep ☐ Yes ☐ No
Snoring ☐ Yes ☐ No
Awakenings at night ☐ Yes ☐ No
(Including choke or gasp)
Observed apneic episodes ☐ Yes ☐ No
Last sleep study (month/year) _____
Have you been diagnosed with sleep apnea? ☐ Yes ☐ No
Year diagnosed _____
CPAP used ☐ Yes ☐ No
Setting _____

9. **Barrett's esophagitis** ☐ Yes ☐ No Year diagnosed _____

10. **Hiatus hernia** ☐ Yes ☐ No Year diagnosed _____
Upper GI series ☐ Yes ☐ No
Endoscopy ☐ Yes ☐ No

11. **Gastroesophageal reflux (GERD)** ☐ Yes ☐ No Year diagnosed _____
☐ Taking medication for GERD

12. **Gallbladder disease** ☐ Yes ☐ No
How was it diagnosed? ☐ Ultrasound ☐ Physical exam
Year diagnosed _____
Did you have your gallbladder removed? ☐ Yes ☐ No
If yes, was it removed: ☐ Laparoscopically ☐ Open procedure

13. **Stress incontinence** ☐ Yes ☐ No
(Leakage of urine with laughing/coughing/sneezing)
Wear pads frequently ☐ Yes ☐ No

14. **Diagnosis of Chronic Joint Disease** ☐ Yes ☐ No
How was it diagnosed?_____Year:_____
What treatments have been prescribed to you by a medical doctor (check all that apply):
☐ Physical therapy ☐ Lifestyle modification
☐ Medication Type of medication: _____
☐ Surgery Type of surgery: _____

Patient Name_____

15. **Can you walk unassisted?** ☐ Yes ☐ No
If no, do you use a: cane . . . . . ☐ Yes ☐ No
walker . . . . . ☐ Yes ☐ No
wheelchair . . . ☐ Yes ☐ No

16. **Weight related injuries and trauma** _____

17. **Swelling in legs** ☐ Yes ☐ No

18. **Thyroid disease** ☐ Yes ☐ No
☐ Taking medication for thyroid disease

19. **Have you ever been on a blood thinner to prevent or treat the formation of blood clots?**
☐ Yes ☐ No

20. **Do you have a personal history of blood clots in your arms, legs or lungs?** ☐ Yes ☐ No
☐ Warfarin ☐ Coumadin ☐ Lovenox ☐ Heparin ☐ Other _____

21. **Do you have a personal history of problems with your blood being too thin or too thick?**
☐ Yes ☐ No

22. **Deep Venous Thrombosis** ☐ Yes ☐ No Year Diagnosed: _____

23. **Pulmonary Embolism** ☐ Yes ☐ No Year Diagnosed: _____

24. **Hepatitis** ☐ Yes ☐ No Year Diagnosed: _____
Which type ☐ A ☐ B ☐ C ☐ Unknown

25. **Cancer** ☐ Yes ☐ No Year Diagnosed: _____
Type:_____
Treatment: _____

26. **Irregular period of infertility**(for female patients only) ☐ Yes ☐ No
If yes, please explain: _____

Patient Name_____

Please list any additional health conditions you currently have:					
Condition	Date	Comments	Condition	Date	Comments

Please circle or add all major operations or surgeries					
Surgery	Date	Surgery	Date	Surgery	Date
None		Colon		Joint Replacement	
Appendectomy		Coronary Artery Stent		Spine	
Breast Augmentation		Cosmetic Surgery		Thyroid Surgery	
Breast Surgery		Eye		Tonsillectomy	
Cesarean Section		Fracture Repair		Tubes Tied	
Heart Bypass		Hernia repair		Heart Valve surgery	
Gallbladder		Hysterectomy		Ovaries	
Bariatric Surgery					
Other:					
Other:					

Hospitalizations		
Reason	Year	Comments

Patient Name____

Family Medical History

	Age	Status: Alive or Deceased	Cancer	Depression	Diabetes	High Blood Pressure	Heart Disease	Obesity	Alcohol Abuse	Drug Abuse	Arthritis	Asthma	Birth Defects	COPD	High Cholesterol	Hearing Loss	Kidney Disease	Mental Illness	Miscarriages	Stroke	Vision Loss	Alzheimer	Other:
Mother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children: M or F			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Adopted ☐ Family History Unknown

Social History

Alcohol Use	☐ YES ☐ NOT CURRENTLY ☐ NEVER DATE OF LAST DRINK:
How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or Less ☐ 2-4 per month ☐ 2-3 per week ☐ 4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
How often do you have 6 or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
Glasses of wine per week	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Cans of beer per week	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Shots of liquor per week	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Mixed drinks with 0.5 ounces alcohol per week	○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Patient Name_____

Sexual Activity			
Sexually active?	☐ Currently	☐ Never	☐ Not Currently
Sexual Partners?	☐ Men	☐ Women	☐ Both
Birth control used:			

Drug Use	☐ YES ☐ NOT CURRENTLY ☐ NEVER Date of last use:			
☐ Amphetamines	☐ Benzodiazepines	☐ "Crack" Cocaine	☐ Cocaine	☐ Heroin
☐ Methamphetamine	☐ PCP	☐ Huff Gasses	☐ Other:	
☐ **Marijuana**: ☐ Edible	☐ Inhalation	☐ THC only	☐ CBD only	☐ Both
Frequency of use: ☐ 1-2	☐ 3-4	☐ 5-6	☐ 7 or more times	☐ Monthly ☐ Weekly ☐ Daily
Tobacco/Nicotine Use	☐ **YES** ☐ **NOT CURRENTLY** ☐ **NEVER** Date of last use:			
Type of Product: ☐ Cigarettes	☐ Cigar	☐ E-Cigarettes/ Vape	☐ Other:	
☐ Smoke every day	☐ Smoke some days	☐ Former smoker	☐ Heavy smoker	
☐ Light smoker	☐ Never smoked	☐ Second-hand exposure		
If ever smoked:	How many packs/day average ☐ ½ ☐ 1 ☐ 1½ ☐ 2 ☐ 3+			
	How many years smoked?			
Have you ever chewed or used snuff?			☐ YES	☐ NO
If you currently use any tobacco/nicotine product, are you ready to quit?			☐ YES	☐ NO
Advanced Directives (Living will and medical power of attorney)				
Do you have an advanced directive?			☐ YES	☐ NO
Would you like information or a copy of advanced directive forms?			☐ YES	☐ NO

Patient Measurement		**Weight History**	**Age**	**Weight**
Height		Birth Weight		
Current Body Weight		After Undergoing Puberty		
Ideal Body Weight		High School Graduation		
Excess Body Weight		Marriage		
10% Pre-Op Excess Body Weight Loss Goal		Lowest Weight in the Past 5 Years		
Target Weight		Highest Weight in the Last 5 Years		
Body Frame (circle one)	☐ Small ☐ Medium ☐ Large			

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight. _____

_____

_____

_____

Patient Name_____

Dietary History

Approximate age when you first seriously dieted. _____

List any physician-supervised and documented weight loss attempts. _____

_____

_____

_____

List the diets and diet programs you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Jenny Craig	Yes No			Yes No	
Nutri-System	Yes No			Yes No	
Weight Watchers	Yes No			Yes No	
Opti/Medi Fast	Yes No			Yes No	
Atkins	Yes No			Yes No	
Keto	Yes No			Yes No	
Intermittent Fasting	Yes No			Yes No	
Zone	Yes No			Yes No	
Low-Carb	Yes No			Yes No	
Paleo	Yes No			Yes No	
Other:	Yes No			Yes No	
Other:	Yes No			Yes No	

List the Medications and Treatments you have tried:

		Date(s)	Duration	MD Supervised (circle one)	Max Loss
Phentermine	Yes No			Yes No	
Contrave	Yes No			Yes No	
Topamax/Topiramate	Yes No			Yes No	
Saxenda	Yes No			Yes No	
Alli/Xenical	Yes No			Yes No	
HcG Shots or Oral	Yes No			Yes No	
Compound Semiglutide	Yes No			Yes No	
Ozempic:	Yes No			Yes No	
Wegovy:	Yes No			Yes No	

Exercise

If you are able to exercise, what kinds of exercise do you do?

Type of Exercise	**Duration** (how long each time)	**Frequency** (times per week)

Patient Name_____

Initial Nutrition Assessment

Please fill out the following information for your appointment with the wellness coach/dietitian. Answer the questions based on the past month of eating habits.

Please check the circle that describes your weight over the past 6 months

- ☐ I've gained weight (If so how much? _____)
- ☐ I've lost weight (If so how much?_____)
- ☐ My weight hasn't changed

Please place a check in the column below that best describes how often you eat the following foods:

FOOD	Daily	2-3 x week	1 x week	Monthly	Less than monthly	Dislike/Never
Meat (Beef/Pork)	☐	☐	☐	☐	☐	☐
Poultry (Chicken/Turkey)	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐	☐
Bread/Tortillas	☐	☐	☐	☐	☐	☐
Pizza	☐	☐	☐	☐	☐	☐
Pasta/Rice	☐	☐	☐	☐	☐	☐
Cheese	☐	☐	☐	☐	☐	☐
Yogurt	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Crackers	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Fried Foods	☐	☐	☐	☐	☐	☐
Fast Foods	☐	☐	☐	☐	☐	☐
Soda	☐	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐	☐
Juice/ Gatorade	☐	☐	☐	☐	☐	☐
Energy Drinks	☐	☐	☐	☐	☐	☐

Please check the circle that describes your daily water intake

- ☐ I drink more than 64 oz of water
- ☐ I drink 32-64oz of water
- ☐ I drink less than 32 oz of water

Are you currently taking a daily multivitamin supplement?

- ☐ Yes
- ☐ No

Please check the circle that describes how many times you eat meals per day

- ☐ 4 or more
- ☐ 2-3
- ☐ 2 or less

Please check the circle that describes how many times you eat snacks per day

- ☐ 4 or more
- ☐ 2-3
- ☐ 2 or less

Patient Name_____

System Review

Please check all symptoms that you currently have. Write in any additional problems.

Head, Eye, Ear, Nose, and Throat □ No Complaints

□ Vertigo	□ headache	□ sinus problems	□ balance disturbances
□ Pain in/around ears	□ nasal congestion	□ double vision	□ decreased night vision
□ Dizziness	□ nasal drainage	□ lump in throat	□ dysphasia
□ Rhinitis	□ hoarseness	□ ringing in ears	□ ear drainage
□ Sore throat	□ blurred vision	□ hearing loss	□ visual aura
□ Uvulectomy	□ buzzing in ears	□ pain with swallowing	

Respiratory □ No Complaints

□ cough	□ bronchitis	□ blood in sputum	□ wake up at night short of breath
□ asthma	□ emphysema	□ out of breath with exertion	□ wake up at night coughing or choking
□ wheezing	□ use two pillows	□ shortness of breath at night	□ _____

Cardiovascular □ No Complaints

□ cold feet	□ heart attack	□ heart murmur	□ squeezing of chest
□ blue toes	□ pain in neck	□ loss of pulses	□ skipping of heartbeat
□ blue finger	□ pains in arms	□ pounding of heart	□ high blood pressure
□ palpitations	□ pains in chest	□ irregular heartbeat	□ abnormal electrocardiogram
□ pain in legs	□ _____		

Gastrointestinal □ No Complaints

□ colitis	□ vomiting	□ irritable colon	□ burning in stomach
□ cramps	□ heartburn	□ acid stomach	□ food sticking in chest
□ nausea	□ gassiness	□ blood in stools	□ belching fluid in throat
□ fissures	□ constipation	□ burning in throat	□ pain with bowel movement
□ diarrhea	□ hemorrhoids	□ pains in stomach	□ _____

Genitourinary □ No Complaints

□ nephritis	□ kidney stones	□ pain with urination	□ trouble stopping urine
□ blood in urine	□ bladder stones	□ small urine stream	□ urinary tract infections
□ kidney failure	□ frequent urination	□ trouble starting urine	

□ leakage of urine with cough or sneeze

□ _____

Men □ No Complaints

□ loss of erection □ painful erection □ discharge from penis

□ _____

Patient Name_____

Women □ No Complaints

□ irregular periods □ vaginal bleeding □ vaginal discharge □ pain with intercourse

□ _____

Endocrine (Glandular) □ No Complaints

□ goiter □ hyperthyroid □ grave's disease □ adrenal gland tumor

□ diabetes □ x-ray to thyroid □ frequent flushing □ frequent heavy sweating

□ low thyroid □ thyroid nodules □ _____

Musculoskeletal □ No Complaints

□ flatfeet □ foot pain □ slipped disk □ broken bones

□ sprains □ knee pain □ fluid in joints □ herniated disk

□ arthritis □ ankle pain □ pain in joints □ swelling of joints

□ sciatica □ warm joints □ low back pain □ redness of skin over joints

□ hip pain □ _____

Neurological □ No Complaints

□ fits □ fainting □ convulsions □ twitching of muscles

□ tremor □ dizziness □ falling at night □ loss of consciousness

□ vertigo □ shakiness □ falling to the side □ pins & needles feelings

□ tingling □ numbness □ weakness of grip □ weakness of any muscles

□ _____

Psychological □ No Complaints

□ major depression (once)
When?_____
□ major depression (twice or more)
When?_____
□ posttraumatic stress disorder
□ borderline personality disorder
□ schizophrenia
□ bipolar disorder
□ manic depression
□ dissociative disorder
□ dissociative identity disorder
□ multiple personality disorder
□ alcohol abuse/dependency
□ drug abuse/dependency
□ psychotic disorder
□ anorexia
□ bulimia
□ generalized anxiety disorder
□ panic disorder
□ panic attacks
□ obsessive compulsive disorder
□ inpatient hospitalization
when: _____
condition: _____
□ psychotherapy
when:_____
condition: _____

Patient Name_____

HonorHealth Bariatric Center
Diagnostic Questionnaire

The following questions are to help us determine a well suited program for your success. Please answer questions accurately to the best of your ability.

1. **Are you normally a large-volume eater at mealtimes?** ☐ **Yes** ☐ **No**

2. **In a typical week, how frequently do you engage in *unplanned* snacking?**

☐ **Many times per day** ☐ **Once per day** ☐ **1-2 times per week** ☐ **3-6 times per week** ☐ **Never**

3. **In a typical month, how frequently do you respond to stress or emotions (sadness, boredom, anger, etc.) by eating or snacking?**

☐ **Daily** ☐ **A few times per week** ☐ **A few times per month** ☐ **Less than monthly**

4. **Name the triggers or sources of stress that may cause inappropriate eating.**

_____, _____, _____, _____

5. **Name your top three favorite foods.**

a._____, **b.**_____, **c.** _____

6. **Do you regularly eat after 7:00 p.m.?** ☐ **Yes** ☐ **No**

7. **Do you typically consider yourself well-disciplined and focused?** ☐ **Yes** ☐ **No**

8. **Have you achieved weight loss through dieting & exercise in the past?** ☐ **Yes** ☐ **No**
   a. **If so, what was your maximum weight loss?** _____**pounds**
   b. **How long did it take to achieve?** _____**months**
   c. **How long did you maintain it prior to regaining weight?** _____ **months**

8. **Do you have either diabetes or insulin resistance?** ☐ **Yes** ☐ **No**

10. **Can you refrain from drinking alcohol?** ☐ **Yes** ☐ **No**

11. **In which bariatric services are you interested?**

□Non Surgical Loss Program **□Explant** **□Sleeve**

□Lap Gastric Bypass **□ Revision** **□ Obesity Medicine program**_____

HONORHEALTH®

Confidential Communications Form

This form helps us understand how you want us to communicate with you, or others, about the care we provide you. You can choose what modes of communication you would like us to use and who we can share information with. We may need to communicate test results, prescription information or respond to a message you left with your physician's office. By completing this form, you understand the following:

- This form gives us permission to communicate with you in a manner that you choose.
- You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone. If you want anything changed on this form, it is your responsibility to contact us to complete a new form. You will be asked to review or update this form at least annually on your next visit to our office.
- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, medications, diagnoses, procedures, etc.
- You understand that your decisions on this form apply to communications made to or from HonorHealth physician offices and not in other locations within HonorHealth (e.g., inpatient hospital).
- You have received a copy of HonorHealth's *Notice of Privacy Practices* and understand other ways HonorHealth can use or disclose your health information not otherwise listed on this form.

Patient Name: _____ MRN: _____

Please tell us how you would like us to communicate information to you by checking all the boxes that apply:

☐ You may contact me by telephone/text/voice mail. Phone number: (_____)_____-_____

☐ You may contact me by e-mail. E-mail address: _____

Please list the name(s) of the person(s) below who you give us permission to communicate your health information and the kind of information you permit us to communicate:

Name and Phone Number	This person's relationship to you	Information we can share (check box)
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information
		☐ Billing information ☐ Appointment information ☐ Medical information

By signing below, you allow us to communicate your health information to you, and permit us to share your health information with other persons, as indicated above.

Patient Name (Please Print)	Patient Signature	Date of Signature
Patient's Legal Representative (if patient can't sign) (Please Print Name)	Patient's Legal Representative Signature	Date of Patient's Legal Representative Signature

HONORHEALTH™

MEDICAL RECORDS RELEASE

I authorize the following physician/facility to disclose information from my health record:

Physician Name_____ **Facility:** _____

Address:_____**City**_____**State**_____**Zip** _____

Phone Number:_____**Fax Number:** _____

PATIENT IDENTIFICATION ***All information must be filled out completely to process your request***	Patient Name Address City State Zip		Date of Birth Phone Number
	Dates of Service: From_____ To_____		
INFORMATION REQUESTED	☐ Office Visit Note(s) ☐ Laboratory Results ☐ EKG Report ☐ History & Physical	☐ Pathology Report ☐ X-Ray Reports ☐ Billing Record	☐ **Other:**
INFORMATION TO BE SENT TO	**HonorHealth Bariatric Center** **10210 N 92nd Street Suite 101** **Scottsdale, AZ 85258** **Phone: 480.882.7460** **Fax: 480.391.3898**		

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that the practice will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. The John C. Lincoln Physician Network Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that I may receive a copy of this authorization.

Unless I revoke this authorization earlier, **it will expire one year from the date signed** or as specified:_____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release the practice, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient **or** Description of Authority to Act for Patient

For Healthcare Use Only

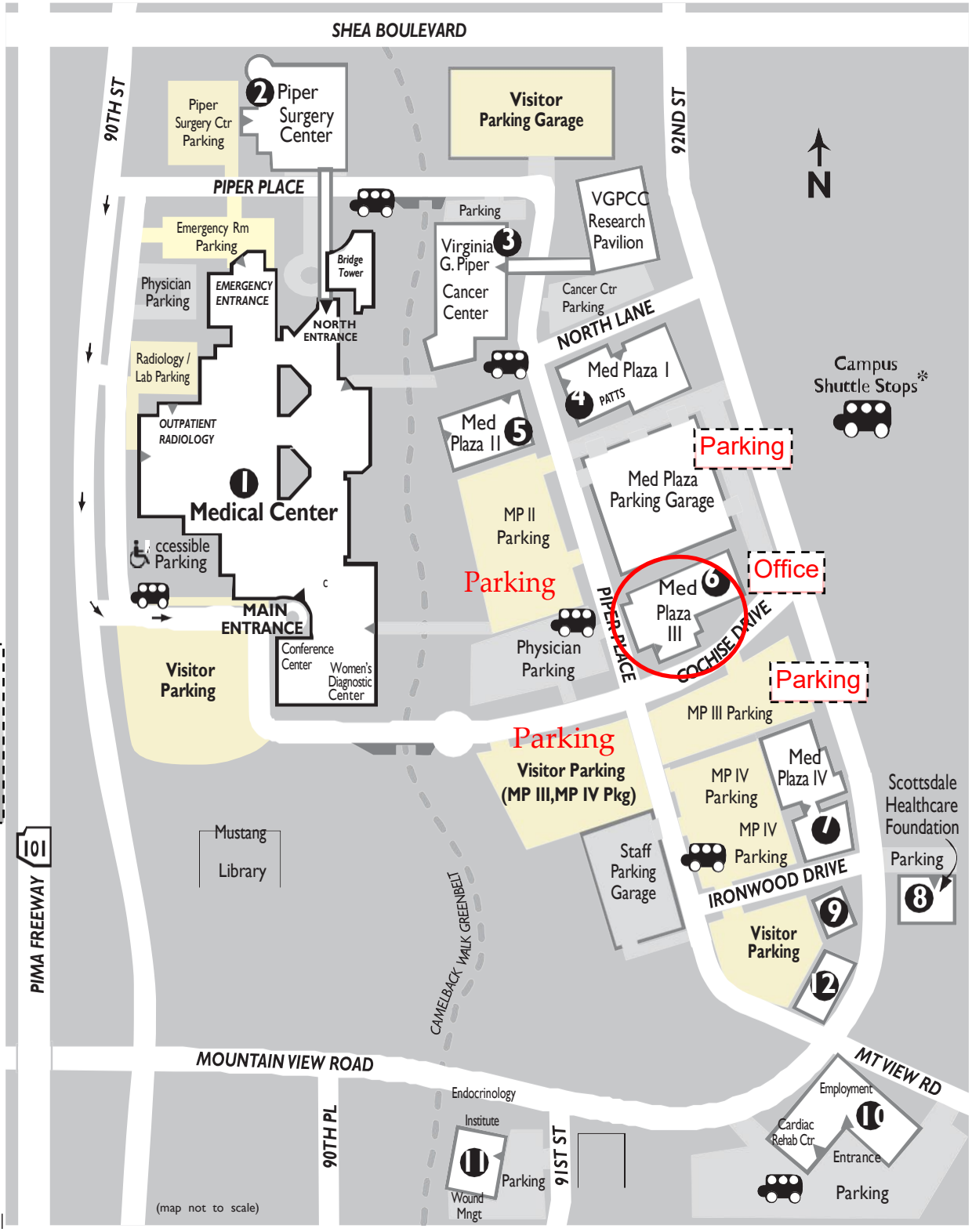
Date Received:_____**Date Sent:**_____**Processor:** _____

PN 200

HONORHEALTH™

Scottsdale Healthcare Shea Medical Center

Campus



Clinic Office
Medical Plaza III
10210 N. 92nd St.
Suite 101
480-882-7460

THIS IS A SAMPLE LETTER- PLEASE PRINT AND GIVE TO YOUR PHYSCIAN TO WRITE THE LETTER ON OFFICIAL LETTERHEAD

(INSERT LETTERHEAD HERE)

(Date)

HonorHealth Bariatric Center
10210 N. 92nd St. #101
Scottsdale, AZ
85258

Re: (insert patient name)
DOB: (insert the patient's date of birth)

Letter of Medical Necessity
(For patients with Medicare or Medicare Advantage plans, a Letter of Medical Clearance or Surgical Risk Assessment must be submitted to obtain authorization for Bariatric Surgery)

To whom it may concern:

(Patient name) is a (age) year-old male/female with a current weight of (weight) and a BMI of (BMI). He/She has suffered from obesity for the past (# of years) years. He/She has the following co-morbid conditions: (insert co-morbidities and any treatments being used). He/She has tried many diets in the past including: (insert any formal weight loss programs the patient has tried including diets, medication, behavior modifications, and exercise programs).

I recommend bariatric surgery be performed at HonorHealth Bariatric Center, which is a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accredited Comprehensive Center with Adolescents.

Sincerely,

(Signature)

THIS IS A SAMPLE LETTER- PLEASE PRINT AND GIVE TO YOUR PHYSCIAN TO WRITE THE LETTER ON OFFICIAL LETTERHEAD