



DeKalb Medical

# Surgical Weight Loss Center

## *New Patient Paperwork*

*Please fill out the attached forms completely and bring with you to your first appointment with Dr. Steinberg or Dr. Rashid.*

*If you are required by your insurance company to have a referral, please make sure you have it faxed to our office at 404.501.7981 in time for your first appointment.*

*Pushing Beyond* —

Welcome to our office!

# Surgical Associates, LLC

2665 North Decatur Road  
Ste. 350  
Decatur, Georgia 30033  
404-501-7081  
Fax 404-419-1680

Surgical Weight Loss Center  
1045 Sycamore Drive  
Decatur, GA 30033  
404-501-7903  
Fax 404-501-7981

**Eugene Harrison M.D. Sidney Stapleton M.D. Scott Steinberg M.D. Qammar Rashid M.D.**

**Patient Information-Please Print Clearly**

**DATE:** \_\_\_\_\_

Patient Name	Social Security #	Date of Birth	Age
Street Address	City/State/Zip Code	Marital Status	Race
Email Address	Home Phone #	Work Phone #	Cell Phone #
Employer	Occupation (Indicate if Student)		
Employer's Address	City/State/Zip Code		
<b>Here to see: Dr. Steinberg Dr. Rashid</b>			
Spouse (Guardian's name if minor)	Phone #		
1. Emergency Contact	(Relationship to Patient)	Phone #	
2. Emergency Contact	(Relationship to Patient)	Phone #	
Referring Doctor name and address	Referring Doctor phone #		
Primary Care Doctor name and address	Primary Care Doctor phone #		

**All patients seen in the Surgical Weight Loss Center will have office visits billed as an Outpatient Facility Charge due to the fact that the Surgical Weight Loss Center is owned by DeKalb Medical.**

**Payment and Release of Information Authorization**

I, \_\_\_\_\_, hereby authorize Surgical Associates, LLC to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. *Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and/or attorney fees associated with my failure to pay my debt.* A photo static copy of this authorization will be as valid as the original.

I hereby authorize Surgical Associates, LLC to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews and any healthcare provider participating in my care, as necessary.

**HIPAA Authorization**

I acknowledge that I have received a copy of Surgical Associates, LLC's Notice of Privacy Practices.

**Signature of Patient :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SURGICAL WEIGHT LOSS CENTER**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

<b>MEDICAL HISTORY - CIRCLE YES OR NO</b>		
High Blood Pressure	No	Yes
Coronary Artery Disease/Heart Attack	No	Yes
Congestive Heart Failure	No	Yes
Diabetes	No	Yes
Sleep Apnea	No	Yes
High Cholesterol	No	Yes
GERD/Reflux/Heartburn	No	Yes
Arthritis	No	Yes
Depression	No	Yes
Thyroid Disease	No	Yes
Epilepsy/Seizures	No	Yes
Blood Clot-Legs/Lungs (DVT/PE)	No	Yes
Peripheral Vascular Disease	No	Yes
Breast Cancer	No	Yes
Colon Cancer	No	Yes
Ovarian Cancer	No	Yes
Kidney Disease	No	Yes
Prostate Disease	No	Yes
Hepatitis	No	Yes
Stomach/Duodenal Ulcer	No	Yes
Irritable bowel	No	Yes
Pancreatitis	No	Yes
Heart Valve Disease	No	Yes
Rheumatic Fever	No	Yes
Glaucoma	No	Yes
Anemia	No	Yes
Mental Illness	No	Yes
Bleeding disorder	No	Yes
Osteoporosis	No	Yes
Stroke	No	Yes
HIV/AIDS	No	Yes
Sexually Transmitted Diseases	No	Yes
Gout	No	Yes
Other:	No	Yes

**ALLERGIES:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SURGICAL HISTORY/HOSPITALIZATIONS:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**  
Current Smoker?      No      Yes  
    packs per day \_\_\_ years \_\_\_  
Past Smoker?      No      Yes  
    packs per day \_\_\_\_\_ # of years \_\_\_\_\_  
    when quit? \_\_\_\_\_  
Alcohol use?    Never    Rare    Sometimes    Often  
    Amount/week: \_\_\_\_\_  
Recreation Drug Use?    No      Yes  
    Drug? \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**  
Mother? \_\_\_\_\_  
Father? \_\_\_\_\_  
Siblings? \_\_\_\_\_  
Other? \_\_\_\_\_

**Surgical Associates, LLC**  
**INSURANCE VERIFICATION FORM**

**Patient Name :** \_\_\_\_\_ **Today's Date:** \_\_\_/\_\_\_/\_\_\_

THE FOLLOWING INFORMATION IS REQUIRED IN ORDER FOR THE OFFICE TO FILE YOUR INSURANCE. FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN YOUR BEING REQUIRED TO PAY FOR YOUR VISIT IN FULL AT THE TIME OF SERVICE.

Are you covered by MEDICARE? \_\_\_\_\_ Medicare # \_\_\_\_\_ Railroad? \_\_\_\_\_

Are you covered by MEDICAID? \_\_\_\_\_ Medicaid # \_\_\_\_\_

**PRIMARY INSURANCE**

**POLICY HOLDER** - Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

POLICY HOLDER SS# \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ INSURANCE CARRIER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ I.D. NUMBER: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

**SECONDARY INSURANCE**

**IF POLICY HOLDER INFORMATION IS THE SAME CHECK HERE** \_\_\_\_\_

**POLICY HOLDER** - Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

POLICY HOLDER SS# \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ INSURANCE CARRIER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ I.D. NUMBER: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

**SURGICAL WEIGHT LOSS CENTER – REVIEW OF SYSTEMS**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Are you CURRENTLY having any problems related to the following? CIRCLE Yes or No

<b>General</b>		
fever or chills	No	Yes
night sweats	No	Yes
generalized weakness	No	Yes
insomnia	No	Yes
weight gain	No	Yes
weight loss	No	Yes
<b>Eyes</b>		
blurry or worsening vision	No	Yes
dry eyes or eye discharge	No	Yes
red or painful eyes	No	Yes
<b>Ears/Nose/Throat</b>		
decreased hearing	No	Yes
ringing in ears	No	Yes
ear pain or discharge	No	Yes
nose bleeds	No	Yes
sinus congestion	No	Yes
hoarseness	No	Yes
sore throat or difficulty swallowing	No	Yes
<b>Respiratory</b>		
shortness of breath or difficulty breathing	No	Yes
chronic cough	No	Yes
coughing up blood	No	Yes
wheezing	No	Yes
<b>Cardiovascular</b>		
chest pain	No	Yes
palpitations	No	Yes
shortness of breath with exertion	No	Yes
swelling in legs or feet	No	Yes
murmur	No	Yes
<b>Gastrointestinal</b>		
abdominal pain	No	Yes
nausea or vomiting	No	Yes
diarrhea	No	Yes
constipation	No	Yes
GERD/heartburn	No	Yes
blood in stool	No	Yes
change in bowel habits	No	Yes

<b>Psychiatric</b>		
depression	No	Yes
panic attacks or anxiety	No	Yes
hallucinations	No	Yes
<b>Musculoskeletal</b>		
muscle weakness	No	Yes
joint aches/pain/swelling	No	Yes
back pain	No	Yes
<b>Neurological</b>		
frequent headaches	No	Yes
dizziness/vertigo	No	Yes
slurred speech	No	Yes
seizures	No	Yes
numbness/tingling in hands or feet	No	Yes
<b>Heme/Lymphatic</b>		
easy bruising	No	Yes
swollen lymph nodes/glands	No	Yes
prolonged bleeding	No	Yes
blood clots	No	Yes
<b>Endocrine</b>		
heat or cold intolerance	No	Yes
excessive thirst	No	Yes
excessive sweating	No	Yes
change in skin color	No	Yes
<b>Genitourinary</b>		
painful or frequent	No	Yes
nocturia	No	Yes
blood in urine	No	Yes
urinary incontinence	No	Yes
frequent urinary infections	No	Yes
decreased libido	No	Yes
erectile dysfunction	No	Yes
kidney stones	No	Yes
<b>WOMEN ONLY</b>		
irregular menstrual periods	No	Yes
heavy menstrual periods	No	Yes
vaginal discharge	No	Yes

HEALTHCARE PROVIDER SIGNATURE AND DATE:



**Outpatient Nutrition Self-Assessment Form**  
(Bariatric)

**Please complete this form (front and back; do not leave anything blank). Write 'None' or 'N/A' if it does not apply to you.**

Date of Nutrition Class/Session: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Do you speak another language besides English?  No  Yes \_\_\_\_\_

Surgeon: \_\_\_\_\_ Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for assessment (Check one):  Gastric Bypass  Lap Band  
 Duodenal Switch

**Anthropometrics: (OFFICE USE ONLY)**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

**Medical History- Check all that apply**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Diabetes*  | <input type="checkbox"/> Gout                          | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Childhood obesity                                    | <input type="checkbox"/> Kidney problems               | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> High blood pressure                                  | <input type="checkbox"/> Urinary problems              | <input type="checkbox"/> premature labor         | <input type="checkbox"/> hepatitis             |
| <input type="checkbox"/> High cholesterol                                     | <input type="checkbox"/> emotional illness             | <input type="checkbox"/> Menstrual problems      | <input type="checkbox"/> seizures              |
| <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Depression                    | <input type="checkbox"/> anemia                  | <input type="checkbox"/> vision difficulties   |
| <input type="checkbox"/> asthma/bronchitis                                    | <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> re-occurring infections |  |
| <input type="checkbox"/> Sleep apnea  | <input type="checkbox"/> circulation problems          | <input type="checkbox"/> tuberculosis            | <input type="checkbox"/> Hypo or hyper thyroid |
| <input type="checkbox"/> Eating disorder ( <b>diagnosed by professional</b> ) | <input type="checkbox"/> sexual difficulties           | <input type="checkbox"/> Sinus problems          |  |
| <input type="checkbox"/> Pain: where? _____                                   | <input type="checkbox"/> bi-polar/other mental illness |  |  |
| <input type="checkbox"/> Other: _____   |  |  |  |

\*If you have **Diabetes**, do you check your blood sugar regularly?  No  Yes (how often)

Tobacco Use:  Yes  No Quit: when? \_\_\_\_\_

Alcohol Use:  Yes  No If yes, how often? \_\_\_\_\_ what type? \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Charge: \_\_\_\_\_

Units: \_\_\_\_\_

**Medications/Vitamins** (you may attach a separate sheet if needed)

Medication	Taken For

**Previous Weight Loss Attempts (Check all that apply)**

Highest Weight \_\_\_\_\_ Lowest Adult Weight: \_\_\_\_\_ Goal Weight: \_\_\_\_\_

Weight Watchers   
  Atkins   
  South Beach   
  Slim Fast   
  Prescription Meds  
 Over-the-counter meds   
  starvation   
  Binge/Purge   
  Jenny Craig  
 Frozen meals   
 Dietitian/Nutritionist   
 Optifast   
 Nutrisystem   
 Overeaters Anonymous  
 Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What is the reason you usually went off a diet?**

\_\_\_\_\_

\_\_\_\_\_

**Exercise**

**Please explain your exercise habits and your attitude about exercise.**

Please check *level of exercise* and *consistency*.

- No exercise   
  1-2 days per week   
  3-4 days per week   
  5-7 days per week  
 Inconsistent   
  Consistent

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is your job active or sedentary?**   
 Active   
 "Desk" job   
 Retired

**Work hours:** \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Charge: \_\_\_\_\_

Units: \_\_\_\_\_



DeKalb Medical

### Social Profile

Are your family/friends supportive of your decision?

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Who is your primary support person?

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### Eating Habits

Are there foods you avoid for religion reasons **OR** other reasons?  No  Yes (please list)

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Do you have any food allergies or intolerances?  No  Yes \_\_\_\_\_

Do you like to cook?  No  Yes

Who does the cooking in your home?  Self  Spouse  Significant Other  Parent  
 Sibling  Other \_\_\_\_\_

How many days per week do you cook/eat at home? \_\_\_\_\_

What are your favorite foods?

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How many times a **week** do you dine out? \_\_\_\_\_

What places do you frequent?

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How many times a **week** do you eat fast food? \_\_\_\_\_

What places do you frequent? (Circle all that apply) McDonald's Burger King  
 Pizza Arby's Chik-Fil-A Subway Dairy Queen Chinese food Checkers Church's  
 Other \_\_\_\_\_

How many times a **day** do you eat sweets? (Candy, cookies, ice cream, cake, donuts, etc) \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Charge: \_\_\_\_\_

Units: \_\_\_\_\_



How many times a day do you drink the following?

Drink	Yes or No	Type	Amount
Juice			
Soda		Reg or Diet	
Iced Tea		Sweet or Unsweet	
Sports Drinks (Gatorade, vitamin water)			
Coffee/Tea What type of sweetener?		Reg or Decaf Sugar, splenda, Sweet N Low, Equal, other	
Water			

Do you add butter, margarine, salad dressing, oil and mayonnaise to your food?

Yes or No. Comments: \_\_\_\_\_

How many fruits do you eat each day? \_\_\_\_\_

How many vegetables do you eat each day? \_\_\_\_\_

Do you eat cheese, yogurt, cottage cheese, milk? Yes or No

Are you lactose intolerant? Yes or No

Circle the protein foods that you enjoy the most:

Red Meat    Chicken    Fish    Eggs    Turkey    Lamb    Pork    Tofu    Nuts  
Peanut butter

Check any of the following that apply to you:

- Eat fried foods often     Eat fast food more than 3x/week     Snack on 'junk food'  
 Eat when bored     Eat late at night     Eat when stressed     Snack frequently  
 Eat fast     Eat less than 3 meals/day     Eat when happy  
 Make yourself vomit if you overeat     Use a laxative if you overeat  
 Eat when upset     Eat when lonely  
 Binge eat (how do you define binge?) \_\_\_\_\_  
 Other \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Charge: \_\_\_\_\_

Units: \_\_\_\_\_



**Food Frequency: How often (per week) do you eat the following foods:**

Food	Times per week	Food	Times per week
Cheese		Beef/Pork	
Milk		Chicken/Turkey	
Yogurt		Seafood	
Vegetables		Peanut butter	
Bread/Starches		Nuts/seeds	
Fruit		Fried foods	
Eggs		Sweets/ice cream	
Chips		Diet foods	
Beans		Convenience foods	

What are your biggest challenges/barriers to eating healthy foods?

- Cost
- Lack of time to prepare shop/prepare meals
- Lack of nutrition knowledge
- Other:

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What type of food (s) do you perceive to be your 'problem food' or (one you can not have a small portion of or stop eating once you start)?

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Do you understand how to read food labels?  Yes  No

If yes, how did you learn? \_\_\_\_\_

Have you learned proper portions of food?  Yes  No

If yes, how did you learn? \_\_\_\_\_

What information do you want to learn in this nutrition session?

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Do you eat in front of the TV?  Yes  No

Do you eat alone or with others most of the time?  Alone  With Others

Patient ID#: \_\_\_\_\_

Charge: \_\_\_\_\_

Units: \_\_\_\_\_



Anything else you want the Dietitian to know about you that would help her to help you with your eating habits?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you learn best?  Audio  Visual  Lecture/Verbal  Reading  Hands-On

How many hours of sleep do you average per night? \_\_\_\_\_  
Is your sleep restful? Yes No

**Expectations of bariatric surgery**

Why did you start seeking bariatric surgery?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you expect from weight loss surgery?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you plan on attending support groups?

\_\_\_\_\_  
\_\_\_\_\_

What needs to happen in order for you to consider surgery a success?

\_\_\_\_\_  
\_\_\_\_\_

Other comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for taking the time to complete this form. Please bring it with you to your appointment.**

Patient ID#: \_\_\_\_\_  
Charge: \_\_\_\_\_  
Units: \_\_\_\_\_