Community Bariatric Surgeons
Email: cconwell@ecommunity.com

PATIENT INFORMATION PROFILE

Please keep this top page for our contact info:

Keith E McEwen MD

9669 East 146th Street
Suite 340
Noblesville IN 46060-4303

Telephone: 317-621-2500 Fax: 317-621-2503

OPTIONS:
Scan packet to: cconwell@ecommunity.com
Fax packet to: 317-621-2503

Before submitting Precertification paperwork to an insurance carrier- we must complete the following appointments as required by all insurance carriers (some carriers require additional items):

1) Surgeon Consult
2) Initial Dietary Consult
3) Initial Psychological Consult

Medicaid Insurance (HIP, Traditional) requires six month supervised weight loss prior to submission, medical clearance, and smoking cessation for 6 months.

We provide **6 months** of Supervised Weight Loss Classes to help patients meet insurance and program guidelines at no cost to our patients. Longer than 6 months or in-depth individual counseling may be additional.

OUR STAFF WILL VERIFY BENEFITS WITH YOUR CARRIER AND HELP YOU NAVIGATE TO MEET THE REQUIREMENTS AND INFORMATION THAT YOUR CARRIER PROVIDES TO US.

Legal Last Name _____First Name_____Date Of Birth_____

Preferred Name to Be Called: _____ Age: _____ Email Address: _____

ADDRESS_____ CITY_____STATE_____ ZIP _____

HOME PHONE_____ WORK PHONE_____EXT_____ CELLPHONE_____

PATIENT'S SOCIAL SECURITY#_____ **PATIENT'S** EMPLOYER_____

PRIMARY Physician's Name: _____ Physician's Telephone # _____

SPOUSE OR Guarantor's Name (AS APPLICABLE) _____ DATE OF BIRTH_____

Guarantor's Social #if necessary for insurance: _____EMERGENCY CONTACT & NUMBER (NOT LIVING WITH YOU) _____

*I UNDERSTAND THAT COMMUNITY BARIATRIC SURGEONS. (D/B/A KEITH E. MCEWEN, M.D, Community Hospitals Indiana.) WILL CONTACT ME AT THE ABOVE TELEPHONE NUMBERS REGARDING APPOINTMENT SCHEDULING, TEST RESULTS, AND OTHER INFORMATION, **UNLESS I REQUEST**, IN WRITTEN FORMAT, AN ALTERNATIVE METHOD TO BE USED.*

INSURANCE INFORMATION: YOU WILL PROVIDE INSURANCE CARD (S) AND WE WILL PHOTOCOPY-

INSURED'S (SUBSCRIBER) INFORMATION (PERSON CARRYING INSURANCE ON ABOVE PATIENT)

INSURED'S NAME (Subscriber) _____ DATE OF BIRTH_____

SOCIAL SECURITY#_____ RELATIONSHIP: SPOUSE PARENT GUARDIAN

INSURED'S EMPLOYER _____ INSURED'S WORK# _____

EMPLOYER'S ADDRESS_____ CITY_____ ST_____ZIP_____

INSURANCE NAME _____ Insurance ID#_____ Group Number: _____

MEMBER SERVICES Telephone#_____ Precertification Telephone #_____

IS THERE **SECONDARY/SUPPLEMENTAL** INSURANCE? YES OR NO

INSURED'S NAME (Subscriber) _____ DATE OF BIRTH_____

INSURANCE NAME _____ Insurance ID#_____ Group Number: _____

MEMBER SERVICES Telephone#_____ Precertification Telephone #_____

Please note- smoking cessation is required upon entering the program. Many insurance carriers require a nicotine test. Please discuss this with our nurse or dietitian.

I hereby authorize my insurance carrier, Medicare, supplemental carrier, or worker's compensation carrier to directly pay COMMUNITY HOSPITAL INDIANA for services rendered to me. I authorize COMMUNITY HOSPITALS OF INDIANA to release my personal health information to only those parties entitled to my information such as, other physicians, insurance carriers, Medicare and treating facilities. I have been offered or given a copy of COMMUNITY HOSPITALS OF INDIANA, HIPAA/privacy act compliance form effective 4/1/2002.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **TODAY'S DATE**

Patient Signature _____ Date_____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____ First Name _____ Date Of Birth _____

Health Information

Do you have ALLERGIES? Yes □ No □

If Yes, list allergy & the reaction (breathing, swelling, rash, etc)

_____

_____

_____

_____

History of Previous Surgeries Yes □ No □

If yes, list:

_____

_____

_____

_____

Approximate Height _____

Approximate Weight _____

Staff total BMI _____

List of Medications: _____

_____

_____

_____

_____

_____

_____

_____

_____

Alcohol Abuse (within past 12 months	Yes □	No □	Arthritis	Yes □	No □
Anemia	Yes □	No □	Back pain	Yes □	No □
Asthma	Yes □	No □	Hip Pain	Yes □	No □
Autoimmune Disease	Yes □	No □	Knee Pain	Yes □	No □
Lupus	Yes □	No □	Foot pain	Yes □	No □
Crohn's Disease	Yes □	No □	Lower Leg Swelling	Yes □	No □
MS (multiple sclerosis)	Yes □	No □	History of Stroke	Yes □	No □
HIV	Yes □	No □	History of Nausea with Anesthesia	Yes □	No □
Rheumatoid arthritis	Yes □	No □	History of problems with Anesthesia	Yes □	No □
Infectious Disease	Yes □	No □	Kidney or Renal Disease	Yes □	No □
Bleeding and/or clotting Disorder	Yes □	No □	Neurological disease	Yes □	No □
Clot (PE) Pulmonary Embolism	Yes □	No □	Urinary Disorder	Yes □	No □
COPD	Yes □	No □	History of Depression	Yes □	No □
Cirrhosis of the Liver	Yes □	No □	History of Mental Disorder	Yes □	No □
Diabetes	Yes □	No □	History of Physical Disability	Yes □	No □
Type 1	Yes □	No □	History of Illicit Drug Use	Yes □	No □
Type 2	Yes □	No □	**Portal Hypertension**	Yes □	No □
History of Diabetes when Pregnant	Yes □	No □	Seizure History or Epilepsy	Yes □	No □
Esophageal or Gastric Varices	Yes □	No □	*Sleep Apnea*	Yes □	No □
GERD or REFLUX	Yes □	No □	Do you use a CPAP	Yes □	No □
Heart Disease	Yes □	No □	Steroid use in past 2 months	Yes □	No □
Hepatitis or Liver Disease	Yes □	No □	TB (tuberculosis)	Yes □	No □
High Blood Pressure (HTN)	Yes □	No □	**Tobacco Use current:**	Yes □	No □
High Cholesterol or Lipids	Yes □	No □	**smoking cessation is required		
History of Cancer	Yes □	No □	If prior use: #PPD? _____ How Long? _____		
History of Chronic Pancreatitis	Yes □	No □	ULCER history (gastric or Duodenal)	Yes □	No □

Staff Notes for Positive Answers

Patient Signature _____ Date _____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

GASTROESOPHAGEAL REFLUX / INDIGESTION HISTORY/GERD

Do you have a history of heartburn or indigestion? Yes No Details: _____
If yes, how often do you have reflux during the day? Daily Weekly Occasionally
If you have reflux at night, how often: Nightly Weekly Occasionally

What aggravates or causes your reflux? Details: _____
Do you have difficulty swallowing? Yes No Details: _____
Does food ever get stuck? Yes No Details: _____
Does food or fluid reflux into the mouth? Yes, No Details:_____
Do you suffer from a regular cough at night? Yes No Details: _____
Please list any treatments you may use for reflux/heartburn or indigestion: _____
Have you had a recent Endoscopy? Yes No Details: _____

SOCIAL PROFILE

Children/Ages: _____
Support persons/friends: _____

FAMILY HISTORY	MOTHER	FATHER	BROTHER/ SISTER	CHILD	NO FAMILY HISTORY
Asthma					
Diabetes					
Fatty liver disease (NAFLD)-non-alcoholic					
Gallstones/gallbladder disease					
Heart Disease					
Hypertension					
Obesity					
Osteoporosis					
Snoring/sleep Apnea					

FEMALES ONLY: (please circle)

Have you had a tubal ligation? Yes or No
Do you have regular periods (26 - 33 days)? Yes or No
Do have problems with excessively heavy periods? Yes, or No
Have you suffered from excess body hair or acne? Yes or No
Have you had a hysterectomy? Yes or No
Do you currently have problems with infertility? Yes or No
Have you had difficulty in conceiving in the past? Yes or No
Do you have polycystic ovarian disease PCOD? Yes or No

WEIGHT LOSS HISTORY ATTEMPTS circle please

Adipex	Atkin's	Cabbage Soup	Dexatrim
Gloria Marshall	Grapefruit	Herbalife	Hoodia
Jenny Craig	Low Calorie	Low Fat	Mayo Clinic
Meridia	NutriSystem	Optifast	Overeaters Anonymous
Physician Weight Loss	Prozac	Redux	Phentermine
Richard Simons-Deal a meal	Slim Fast	South Beach	Fen Phen
Sugar Busters	Suzanne Somers	Weight Watchers	Xenical
Zone Diet	LA weight loss	Tburner	Other: _____

What was **the most weight** that you lost or range of Weight loss with the before mentioned methods? _____
_____

Patient Signature _____ Date_____
Printed Name _____
Staff Signature _____ Date _____

Legal Last Name _____ First Name _____ Date Of Birth _____

Behavior Contract for Patients:

You are being considered to enter a Bariatric Program or have been accepted for bariatric surgery with Community Bariatric surgeons, Keith E. McEwen MD. The success of a Bariatric procedure depends on you following a medical, behavioral, and nutritional program that includes clinic visits, an exercise program, dietary guidelines, and taking any recommended vitamins and/or minerals as prescribed.

By Signing below, you are agreeing to make a commitment to yourself and your Bariatric Team on the following items:

1. I will follow the treatment plan as prescribed by my surgeon and Bariatric team. I will keep my clinic appointments, complete all mandatory labs, and take my medicine as directed. I will read the pre and post-surgery educational materials provided to me by the staff and ask questions about any content that I do not understand. I will bring the materials to the hospital and/or clinic when requested.
2. I will participate in the exercise plans as recommended by my surgeon and /or my Bariatric team. I understand the Bariatric team may recommend a formal outpatient program or may recommend general exercise guidelines for home.
3. I will follow the nutritional guidelines and restrictions as prescribed by the clinical Dietitian. I understand that I am placed on a weight loss regimen and I must demonstrate continued appropriate weight loss through compliance with the recommended nutrition guidelines. I understand that these dietary changes, such as a healthy, well-balanced diet, will be crucial to my overall health after surgery. I will be asked to food journal for the dietitian and I will comply for my success.
4. I will meet with the Bariatric Dietitian regularly to review my diet record and nutritional needs. I will complete daily food records at the Dietitian's request that will include all food and fluids consumed during the day. I will bring food records to appointments or forward them to the Dietitian.
5. If alcohol abuse and/or dependence has been identified as an issue for me, I commit to psychological intervention as deemed necessary. I must demonstrate 12 months of abstinence before being considered a candidate for Bariatric surgery.
6. I will not use any substances or drugs not prescribed by a physician. I will use prescription drugs as prescribed. I must demonstrate 12 months of abstinence from undesirable/illicit drugs before being considered a candidate for Bariatric surgery.
7. I commit to participating in any needed treatment programs to address substance abuse issues. I agree to sign a release of information document to allow the Bariatric team to monitor my progress and attendance in the chosen treatment program.
8. I commit to completing the requirements of the clinical psychologist pre surgically and/ or post surgically. I commit to learning, resolving, and changing my specific situations, behaviors, weight loss barriers, emotions, or triggers and to seek immediate assistance if not in compliance. I understand that if I do not satisfactorily complete the clinical psychologist's pre surgical requirements, I will jeopardize my suitability as a candidate for Bariatric surgery.
9. I commit to attending support groups as much as physically possible. I understand this is an important aspect of the program and an opportunity to receive ongoing education, support, and meet other Bariatric surgical patients.
10. I will contact the Bariatric team with any pre/post-surgical medical questions or changes in current health status. I will forward all required labs to the staff and follow given recommendations.
11. I understand that if I break this contract I could jeopardize my health, weight loss success, and/or suitability as a candidate for Bariatric surgery. I understand that in changing and/or maintaining healthy behaviors, relapses/lapses can occur. I commit to learning my specific situations, behaviors, or triggers for a relapse, pre and post surgically, and to seek immediate assistance to bring these under control. If I feel like I am going to break this contract, I will call a member of the Bariatric team for assistance. The Bariatric team agrees to provide names and teams of psychologist or therapist if or when necessary.
12. When I receive the Bariatric surgery, I understand that these requirements continue as a lifetime commitment. I take personal responsibility for my program success and will initiate follow-up as indicated with Bariatric team members.
13. I understand that if weight gain occurs during supervised weight loss (before surgery) that the program requirements, industry standards, and many insurance policies require, that my surgery be cancelled or postponed until my weight loss goals have been met. This is for safety during the surgery process.
14. I understand that I must **complete all required appointments, pre-op classes, psychology clearance and online education.** Any recommendations must be completed prior to scheduling surgery.
    Your initial evaluation with the psychologist will give insight into your behaviors.
    The pre-op nutrition and behavioral skills classes will provide vital information including nutrition, exercise, and behavioral modification. These appointments are required.

Patient Signature _____ Date _____
Printed Name _____
Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

Behavior Contract for Patients Continued:

15. I understand that SMOKING cessation is required before surgery. M**any insurance policies mandate that patients are NICOTINE free for at least three to six months prior to surgery. Please check your policy.** We will screen for nicotine levels as indicated and if there are any positive results, your surgery will be delayed. If you need assistance, please consult your primary care physician or the bariatric team for further information on cessation programs.
16. **Please give 24 hours' notice if you need to cancel or reschedule an appointment. If you cancel late within 24 hours or do not show for an appointment, you can be discharged from our program.**
17. **NO SHOW /NO CALL for an appointment policy. If you NO SHOW or NO CALL with a provider - you can and WILL be discharged from the program. We understand that situations occur but we do expect a telephone call.**

I understand that if I do not complete and comply with the requirements made by the bariatric team, I could jeopardize my health, weight loss success, or my suitability as a candidate for surgery. I understand that bariatric surgery is only a tool and will not guarantee my weight loss. After I receive bariatric surgery, I understand that these requirements continue as a lifetime commitment. I take personal responsibility for my success and will initiate follow up as recommended by the bariatric team.

_____ _____

Patient Signature **Date**

Where did you hear about our program or DR. McEwen?

TV program_____ Internet: _____

Facebook_____ Friend: (please include name) _____

Newspaper or Brochure_____ Physician: _____

If a physician referred, please complete:

Referring Doctor: _____Telephone#: _____

Address: _____ City:_____State_____Zip_____

What has been your biggest obstacle to moving forward with Lap Band System® or Bariatric Surgery:

(circle all that apply):

Fear of Weight Loss Surgery

Fear of "never being able to eat and enjoy"

Awareness of a friend, coworker, family member that had a "bad" result

Stigma of Weight Loss Surgery (afraid others will judge your decision)

Lack of Physician Support and/or Lack of Family Support

Insurance coverage and/or Financial concerns

Fear of Failure

Patient Signature _____ Date_____

Printed Name _____

Staff Signature _____ Date _____

Legal Last Name _____First Name_____Date Of Birth_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*give this to your Primary Care Physician

I give my permission to release my medical information to Community Bariatric Surgeons, Community Hospital Indiana, and Keith E. McEwen, M.D.

Release the following information:

- ☐ The medical record pertaining to weight loss:
  - One weight (preferably the highest) for the PAST 5 YEARS
  - Any Consecutive Weight Loss appointments of counseling for weight, and/or use of prescription weight loss drugs
  - Pertinent Lab Results from the last 12 months (A1C, Thyroid, Glucose, ETC)
  - EKG or Stress Test from last 12 months
  - Cardiac Results or Studies
  - Diabetic Results or Counseling
  - Any Endoscopy from the last 3 **years**
- ☐ Other _____

I hereby authorize release of such information to the above to include any and all medical records concerning my medical history, physical condition, diagnoses, treatment and/or prognosis, including X-rays and other diagnostic reports, as well as, any information contained in my medical reports or records that relate to treatment and/or history of psychiatric or mental health problems, drug or alcohol abuse problems, dangerous or any communicable diseases, including AIDS or tests for infection with HIV, any other information related to my treatment.

This information is being requested for the following purpose:

Appointment with Dr Keith McEwen (Community Bariatric Surgeons) in regards to Weight Loss Surgery (Lap Band System®)

This release shall apply to any and all data listed above unless otherwise indicated by the patient as follows:
Do not release information contained in my record regarding:

_____

Patient Name:_____Date of Birth: _____
Release only records for the dates of _____through _____

Patient/Consenting Party Signature: _____Date: _____
(Guardian or Legal Representative if patient under 18 years old)

A photocopy of a signed authorization is acceptable, providing that it is apparent that following the photocopying of the authorization on line the signature or the date is not added. This authorization is valid for sixty (60) days after the date of this request is made, unless otherwise stated. I understand this consent can be revoked at any time to the extent that disclosure is made in good faith has already occurred in reliance on this consent.

Telephone: 317-621-2500 **Fax: 317-621-2503**

Mailing Address:

Community Bariatric Hamilton-Keith McEwen MD
9669 East 146th Street #340
Noblesville IN 46060

Patient Signature _____ Date_____
Printed Name _____
Staff Signature _____ Date _____