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Richard Greco, DO
James Nangeroni, DO
Marius Calin, M.D.

NJ Weight Loss Doctors
Specialists in Weight Loss Surgery

Seminar:	Office Visit:	Surgical Date:	**RNY/BAND/SLEEVE**
Name: Please include maiden or previous name		Primary Physician:	
Address:		Physician Phone:	
		Name of Pharmacy:	
City, Zip Code, State:		Pharmacy Phone #:	
Preferred Phone #		Alternate Phone #	
DOB:	Age: / Sex: M / F	Marital Status:	SS#
Email Address:		Emergency Contact Name / Relationship / Phone#:	
Employment Status: ☐ Full Time ☐ Part Time ☐Self Employed ☐ Retired Student ☐ Unemployed			
Occupation:	Employer:		Business Phone:

INSURANCE INFORMATION – PLEASE PROVIDE REFERRALS IF REQUIRED

PRIMARY INSURANCE	
INSURANCE COMPANY NAME :	POLICY ID #:
NAME OF SUBSCRIBER:	SUBSCRIBER SS#:
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT:

SECONDARY INSURANCE	
INSURANCE COMPANY NAME :	POLICY ID #:
NAME OF SUBSCRIBER:	SUBSCRIBER SS#:
SUBSCRIBER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT:

CONSULTS – FOR OFFICE USE

Cardio	
Pulmonary	
GI	
Psych	
Nutrition	
PCP / Other	

Medication Log and Co-Morbidity

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

ALLERGIES:				
List of Medications: ******Please Include Over the Counter Medications******				
Name:	Dose	Frequency	Duration	Reason Medication Prescribed
☐ **NSAID warning given**				
Sleep Apnea	☐ CPAP		☐ BiPAP	
Oxygen	☐ 24 hours		☐ During Sleep	

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

OFFICE USE ONLY: List of Co-Morbidities:

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I am entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims on my behalf to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me. In the event that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out to check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for the professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co- payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to : (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R.§2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I understand that my provider may be out of network with my health insurance plan for my scheduled elective procedure. I have been given the contact information for the billing company and am able to request an estimate of my out of pocket cost.

I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Patient Signature _____ Date _____

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Acknowledgement of HIPAA privacy notice and designation of disclosure

Patient Name: _____ Date of Birth:_____

I wish to be contacted in the following manner (check all that apply):

Home/Cell Telephone Number: _____
__Ok to leave a message with detailed information

Written Communication:
__Ok to mail to my home address that I listed on registration.

Email Address: _____
__Ok to contact me via email

Designation of Certain Relatives, Close Friends and Other Caregivers:

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:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____
Print Name:_____Relationship:_____Phone #:_____

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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Pre-Op Patient Assessment Questionnaire

Name		Last			
DOB	Age			☐Female ☐Male	
☐Gastric Bypass ☐LapBand ☐ Sleeve ☐Don't Know					BP
Allergies /Reaction:					
Medications you are currently taking:					

Do you have:

☐Arthritis	☐Fibroids	☐Joint pain or swelling
☐Angina	☐GERD reflux disease	☐Lupus
☐Asthma	☐Gallbladder disease	☐Ovarian Cysts
☐Blood Clots	☐Glaucoma	☐Peptic Ulcer Disease
☐Bleeding Problems /Anemia	☐Hypertension	☐Stroke
☐BPH, prostate disease	☐Heart Attack	☐Shortness of Breath
☐Congestive Heart Failure	☐High Cholesterol (>200)	☐Sleep Apnea
☐Coronary Disease	☐Hypoventilation Syndrome (pCO2>45 or hemoglobin)	☐CPAP ☐BIPAP
☐Colitis	☐Hypothyroid	☐Snoring
☐Cataracts	☐Hepatitis	☐Skin Disease
☐Cancer Tumors If yes, what type	☐Idiopathic Intracranial Hypertension Pseudotumor Cerebri	☐Sexually transmitted disease When _____
☐Diabetes	☐Infertility	Type _____
☐Diverticulitis	☐Incontinence bladder/bowel	☐Venous Stasis
☐Depression	☐Irregular Periods/Last period:	☐ Polycystic Ovary Disease
☐Emphysema	If post-menopausal, since what date:	☐ IVC Filter
☐ Renal Insufficiency / Dialysis	☐ HIV Positve If yes, when_____	☐Pulmonary Emboli
☐COPD		☐ Other

Please List all prior surgeries/hospitalizations/injuries

Operation	Date	Hospital	Surgeon	Any problems

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

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

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Brother	Sister	Other
Obesity								
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?	How long ago did you quit?
Do you drink alcohol? ☐No ☐Yes – If Yes, how much?	Are you oxygen dependent? ☐No ☐Yes
Do you use recreational drugs? ☐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
Functional health status prior to surgery: ☐ Independent ☐ Partially Dependent ☐ Totally Dependent	
If dependent, please explain how :	Is your ambulation limited all or most of the time? ☐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						
Physical Activity						
Socially Involved						
Able to Work						
Interested in Sex						
Financial Well Being						
Participates in Recreation						

Please answer the following regarding your attempts to lose weight

How long have you been over weight?	What was your weight at age 18?
Lowest adult weight in the past 5 years	Highest adult weight in the past 5 years
What was the biggest loss in pounds you had?	How long did it take you to lose the weight?
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?

☐Treadmill	☐Curves
☐Walking	☐Jogging
☐Swimming	☐Personal Trainer
☐Wt. Training	☐Aerobics
☐Bicycle	☐VHS/DVD
☐Pilates	☐Other

How were you referred to 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

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				
Mediterranian				
DASH				
Atkin's Diet				
South Beach Diet				
Health Spas				
Gym/Exercise Program				
Contrave				
Saxenda				
Medication Non prescribed				
Weight Loss Medication				
Medically Supervised Diets				
Others				

If you have surgery. How much weight do you expect to lose?

Did you attend our weight loss Seminar? ☐No ☐Yes – If yes, When?