Whole Health Weight Loss Institute

Scott Perryman, MD, FACS, FASMBS

Complete New Patient Intake Package

Please complete all sections. Bring this completed package to your first appointment, or complete it securely online at whweightloss.com.

Patient Information

Patient First Name: _____ Middle Initial: _____

Patient Last Name: _____ Date of Birth: _____

Address (Street, City, State, ZIP): Sex: _____

_____

Phone — Cell: _____ Ethnicity: _____

Phone — Home: _____ Race: _____

Email Address: _____ SSN: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Referring Physician: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number: _____

Insurance Information

Please provide your insurance information to the receptionist. If the person responsible for the bill is not the same as the person listed above, please complete the fields below.

Full Name: _____ Date of Birth: _____

Insurance Company: _____ SSN: _____

Subscriber ID #: _____ Group #: _____

Relationship to Patient: _____

Signature and Authorization

I verify that the above information is true to the best of my knowledge. I understand that the payment, proof of insurance, and/or copay is due at the time of service. I authorize Medicare or my insurance company to release any information required to process my claims and to pay for the covered services rendered. I understand that I am financially responsible for any balance due.

Signature: _____ Date: _____

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Authorization to Release Medical Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Last 4 Digits of SSN: XXX – XX – _____

I hereby authorize the following health care professional, medical facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer or family member to release all health information about me:

Person/Organization to Release Information: _____

Address: _____

Phone Number: _____ Fax Number: _____

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Whole Health Weight Loss Institute · Phone: (707) 721-3500 · Fax: (707) 721-3499

The following health information that relates to service beginning from _____ to _____ may be released:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Hospital Reports
- ☐ Medication List
- ☐ Treatment Record
- ☐ Operation Reports
- ☐ Other (please specify)

_____

- The above person/organization receiving my medical information, its employees, representatives and any other persons performing services for them or on their behalf may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of providing care or receiving payment for said care.
- This authorization is valid for ONE YEAR following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.
- By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.
- I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient's Signature: _____ Date: _____

Patient's Name (printed): _____

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Practice Policies

We welcome you to our practice and thank you for the opportunity to care for you. To avoid any misunderstanding, please acknowledge your acceptance and understanding of our policies by initialing after each statement below.

Advanced Beneficiary Notice

We expect that there may be times when your insurance company will deem certain services to not be a covered benefit of your policy supplies. If your insurance company denies these items, we ask that you acknowledge this and agree to be financially responsible:

I understand that my insurance carrier may decide to deny certain services as “not a covered benefit of my policy”. Prior to these services being provided I will be given the cost of these items, and I will decide whether I wish to have them or not. In the event that I choose to have these services/items, I agree to be responsible for payment to this practice. I understand that I can appeal my insurance company’s decision to deny payment.

_____ (initial)

Waiver of Benefits

I hereby authorize WHWL (Dr. Perryman) to release information acquired during the course of my examination and treatment to the Centers for Medicare and Medicaid Services (CMS) and its agents or any other third party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of benefits directly to the medical practice of Dr. Perryman.

_____ (initial)

Co-Payment

Co-payment is due at the time of service. Due to increased administrative costs, I hereby agree to a charge of $25.00 for a processing fee. If I do not pay my copayment at the time of service, or if I have not provided correct insurance information, or if my check does not clear the bank for any reason.

_____ (initial)

Missed Appointments

Time reserved for your doctor’s appointment is important. We value you as a patient and make that time for your health needs and concerns. Not showing up for your appointment or failing to notify the office at least 24 hours in advance if you need to cancel, means that we are unable to utilize that time to see other patients. I understand and agree that I will be responsible for a missed appointment fee of $150 for an initial consultation, $75 for a follow up, and $250 for a procedure/surgery, if I fail to show up for my appointment or give cancellation notice of less than 24 hours prior to the scheduled time.

“A holder of this medical debt contract is prohibited by Section 17855.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.”

_____ (initial)

Printed Name: _____

Signature: _____ Date: _____

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Photo Consent Form

This form is entirely optional. Declining will not affect your care or treatment in any way.

I, _____ with a mailing address of _____, city of _____, state _____, grant permission and give my consent to Whole Health Weight Loss (WHWL) for the use of photographs either taken by the physicians and/or staff, or those given to the practice by me (the releasor), for use in marketing and promotion on our website, social media and any other teaching or marketing materials.

Please select one:

☐ I CONSENT to the use of my photographs as described above.

☐ I DO NOT CONSENT. (Your care is not affected by this choice.)

Patient's Signature: _____ Date: _____

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New Patient Questionnaire

Name: _____ Date: _____

How long have you considered bariatric surgery?

_____

How did you first learn of bariatric surgery?

_____

Do you know other patients who have undergone bariatric surgery? ☐ Yes ☐ No

If yes, was the surgery successful?

_____

Are your friends/family supportive of your decision to pursue bariatric surgery? ☐ Yes ☐ No

Have you tried dieting in the past? ☐ Yes ☐ No

How much weight have you lost while dieting?

_____

How many diets have you tried in the past year? ☐ 0 ☐ 1–3 ☐ 3–5 ☐ >5

Have you ever tried the following for weight loss?

☐ Binging and purging
☐ Binging followed by food restriction
☐ Use of laxatives
☐ Use of diuretics
☐ Use of diet pills

What brand of diet pills did you try?

_____

How much did you lose with this type of diet pill?

_____

How long did you use this diet pill?

_____

What is your maximal weight reached in your lifetime? _____ lbs

What is your lowest weight achieved in the past 10 years? _____ lbs

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New Patient Questionnaire (cont.)

Have you ever meditated before? ☐ Yes ☐ No

If yes, how often would you say you meditate? (select one)

☐ Everyday ☐ Once a week

☐ Once a month ☐ Once in a while

☐ I've done it once or twice before

If no, are you open to learning how to meditate?

☐ Yes ☐ No ☐ Maybe

Have you heard of mindful eating? ☐ Yes ☐ No

Do you feel there is a connection between how you feel and your thoughts and actions? ☐ Yes ☐ No

Do you consider yourself to be an emotional eater?

☐ Yes ☐ No ☐ I'm not sure

What do you feel is the main reason that you are overweight?

☐ Eat too many high-calorie sweets

☐ Eat too much normal food

☐ Eat too much normal food and high-calorie sweets

☐ I have an abnormal metabolism

☐ I have a disability that limits my movement

What is your personal goal weight with surgery? _____ lbs

What is your main reason for trying to lose weight?

_____

_____

Medical History

Do you have any of the following medical problems?

Diabetes ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

High cholesterol ☐ Yes ☐ No

High triglycerides ☐ Yes ☐ No

Pre-diabetes ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Obstructive sleep apnea ☐ Yes ☐ No

GERD / reflux / heartburn ☐ Yes ☐ No

Polycystic ovarian syndrome ☐ Yes ☐ No

Pain? Please select all that apply:

☐ Back ☐ Foot/Ankle ☐ Knee ☐ Hip

Have you ever had surgery before? ☐ Yes ☐ No

Please list operations below:

_____

_____

Family medical history (medical conditions in other family members):

_____

_____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

Are you a former smoker? ☐ Yes ☐ No

If yes, when did you quit? _____

How many alcoholic drinks do you drink? Please select all that apply:

Drinks: ☐ 0 ☐ 1–3 ☐ 3–5 ☐ >5

Frequency: ☐ Per day ☐ Per week ☐ Per month

Medication list (please list below):

Symptoms

Symptoms (select all that apply):

- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of consciousness
- ☐ Chest pain / palpitations
- ☐ Shortness of breath
- ☐ Cough
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Pain with urination
- ☐ Blood in the urine
- ☐ Frequent urination
- ☐ Tingling (hands or feet)
- ☐ Weakness
- ☐ Fevers
- ☐ Chills
- ☐ Breast pain
- ☐ Breast drainage/discharge
- ☐ Breast lumps

Other symptoms not mentioned above:

_____

_____

Allergies:

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Updated STOP-BANG Questionnaire

Snoring?

☐ Yes ☐ No Do you snore loudly? (Loud enough to be heard through closed doors, or your bed-partner elbows you for snoring at night?)

Tired?

☐ Yes ☐ No Do you often feel tired, fatigued, or sleepy during the daytime? (Such as falling asleep while driving or talking to someone?)

Observed?

☐ Yes ☐ No Has anyone observed you stop breathing or choking/gasping during your sleep?

Pressure?

☐ Yes ☐ No Do you have, or are you being treated for, high blood pressure?

Body Mass

☐ Yes ☐ No Body Mass Index more than 35 kg/m²?

Age

☐ Yes ☐ No Age older than 50 years old?

Neck Size Large?

☐ Yes ☐ No (Measured around Adam's apple) For males, is your shirt collar 17 inches / 43 cm or larger? For females, is your shirt collar 16 inches / 41 cm or larger?

Gender? (Please select one)

☐ Male ☐ Female

Patient's Signature: _____ Date: _____

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