

Stanley D. Hoehn, M.D.  
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Robert J. Aragon, M.D.

# THE **Bariatric Center** OF KANSAS CITY

23401 Prairie Star Parkway, Suite B300, Lenexa, Kansas 66227  
Phone: (913) 677-6319 Fax: (913) 677-1540

## Seminar Attendance Verification & Return of Medical Records Policy

Thank you for your interest in our program. By signing this form, I verify that I have attended or watched the free patient informational seminar presented by our doctors. With my signature, I agree that the information presented to me throughout the seminar is understood. I also understand that any medical records obtained for determination of qualification for surgery will not be returned to me if I am not a candidate for surgery with this program. The records will be destroyed 30-days after notification of non-candidacy.

Once you and your surgeon decide to proceed with surgery, the services listed below are required to provide for your safety and our quality standards. Insurance **may** cover the following:

- Physician and Dietitian appointment(s)
- Psychology appointment(s)
- Upper Endoscopy (EGD)
- Home Sleep Testing (HST)
- Laboratory testing

Last Name (print): \_\_\_\_\_

First Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Seminar Attendance: \_\_\_\_\_

Surgeon Preference (chose one):     Stanley Hoehn     G. Brice Hamilton     Robert Aragon

How did you hear about The Bariatric Center of Kansas City?

Physician Referral     Personal Referral     Google Ad     Internet Search     Instagram     Facebook

Advent Health Website     Other: \_\_\_\_\_

Name of the person / entity that referred you: \_\_\_\_\_

OFFICE USE ONLY:     SDH     GBH     RDA    Date Received: \_\_\_\_\_    Case Manager: \_\_\_\_\_

### Patient Demographics

To expedite the process of new patient information, please be sure to include a **CLEAR** copy of the front & back of your INSURANCE CARD(S) and a copy of the front of your DRIVER'S LICENSE. Be sure to **FULLY COMPLETE** this new patient informational / medical history packet. *Incomplete information may delay our ability to process new patient intake.*

*~ Please complete using blue or black ink only – thank you! ~*

\_\_\_\_\_  
**Last Name**

\_\_\_\_\_  
**First Name**

\_\_\_\_\_  
**Middle Initial**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Social Security Number**

Male  Female

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Apartment**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Cell Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Email Address**

\_\_\_\_\_  
**Age**

\_\_\_\_\_  
**Height**

\_\_\_\_\_  
**Weight**

\_\_\_\_\_  
**BMI**

\_\_\_\_\_  
**Neck Circumference**

**Marital Status:**  Married  Single  Separated  Divorced  Widowed  Undisclosed

**Ethnicity:**  Caucasian  African American  Native American  Asian  Hispanic  Pacific Islander / Hawaiian

**Employment:**  Employed/Self Employed  Domestic Engineer  Student  Retired  Disabled  Unemployed

Full Time  Part Time

\_\_\_\_\_  
**Employer**

\_\_\_\_\_  
**Occupation**

**Do you have health insurance?**  Yes  No

**Have you had a previous bariatric surgery?**  Yes  No

**Surgical Interest:** \_\_\_\_\_

### Consent to Release & Authorize Insurance Information

Insurance information is required, even if privately paying for surgery; Please be sure to **FULLY** complete this form.

#### Primary Insurance

\_\_\_\_\_  
**PRIMARY** Insurance Company

\_\_\_\_\_  
Policy Subscriber's Full Name  Patient is Primary Subscriber

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Subscriber's Social Security Number

\_\_\_\_\_  
Subscriber's Birth Date

\_\_\_\_\_  
Subscriber's Employer

\_\_\_\_\_  
Customer Service Phone Number

**Relationship:**  Self  Spouse  Child  Other: \_\_\_\_\_

\*\*\*\*\*

#### Secondary Insurance

\_\_\_\_\_  
**SECONDARY** Insurance Company

\_\_\_\_\_  
Policy Subscriber's Full Name  Patient is Primary Subscriber

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Subscriber's Social Security Number

\_\_\_\_\_  
Subscriber's Birth Date

\_\_\_\_\_  
Subscriber's Employer

\_\_\_\_\_  
Customer Service Phone Number

**Relationship:**  Self  Spouse  Child  Other: \_\_\_\_\_

\*\*\*\*\*

#### Tertiary Insurance

*Please include a clear copy of the front & back of tertiary insurance card, if applicable*

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I authorize the office of Stanley D. Hoehn, M.D., G. Brice Hamilton, M.D., and Robert D. Aragon, M.D. (KC Bariatric, LLC) to release my personal and confidential information to my health insurance carrier for the purpose of verifying my coverage, benefits, payment information and researching coverage criteria &/or requirements.

\_\_\_\_\_  
**Patient or Authorized Representative Signature**

\_\_\_\_\_  
**Patient** (and Authorized Representative) **Name Printed**

\_\_\_\_\_  
**Patient's Date of Birth**

\_\_\_\_\_  
**Today's Date**

### Privacy Release Authorization

I, \_\_\_\_\_, hereby give permission for KC Bariatric, LLC physician(s) and office staff to discuss my medical condition and care &/or billing information with the following person(s):

Name	Relationship	Phone Number
<input type="checkbox"/> Authorized to discuss <i>MEDICAL CONDITION AND CARE</i>	<input type="checkbox"/> Authorized to discuss <i>BILLING INFORMATION</i>	

\*\*\*\*\*

I, \_\_\_\_\_, hereby give permission for KC Bariatric, LLC physician(s) and office staff to contact me at my listed phone number(s) and authorize the following (initial all that apply):

You have my permission to identify your office when calling my  **HOME**  **CELL**  **WORK** phone number(s) and to leave an abbreviated message on my voicemail or with a person identified above. \_\_\_\_\_(INITIAL HERE)

You have my permission to identify your office when calling my **WORK PHONE NUMBER** and leave the caller's name and phone number on my  **WORK VOICEMAIL** ( and / or )  **WITH A CO-WORKER.** \_\_\_\_\_(INITIAL HERE)

**DO NOT** leave a message indicating any other information besides  **PHYSICIAN'S NAME**  **PRACTICE NAME** and **CALLER'S NAME AND RETURN PHONE NUMBER ONLY.** \_\_\_\_\_(INITIAL HERE)

**DO NOT LEAVE ANY KIND OF MESSAGE AT ALL.** \_\_\_\_\_(INITIAL HERE)

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## Bariatric Program Fee

A Program Fee of \$250 applies to ALL bariatric surgery patients. This Program Fee is for services not covered by your insurance carrier for bariatric surgery and the Fee will NOT be billed to your insurance. However, if you have a Flexible Spending Account, you may be able to use those funds to apply towards the Program Fee. The Program Fee is a separate charge not applicable to co-pays, deductibles and co-insurance charges required by your health insurance plan.

The services that your insurance carrier will not cover include, but are not limited to the following:

- 24 hour access to KC Bariatric medical providers
- Ongoing dietary support and materials
- Monthly support groups
- Special bariatric conferences and events
- KC Bariatric newsletters, continuing education and other materials

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Please check and initial one option for payment. You will be expected to comply with the option that you choose:

I would like to pay the \$250 Program Fee in full at my first surgeon visit \_\_\_\_\_(INITIAL HERE)

I would like to pay the \$250 Program Fee in three (3) installments with my first payment in the amount of \$83.34 due on the first surgeon visit. The remaining two (2) payments of \$83.33 will be set up on a payment plan. \_\_\_\_\_(INITIAL HERE)

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I UNDERSTAND MY CASE WILL NOT BE SUBMITTED UNTIL PAYMENT OF \$250 IS PAID \_\_\_\_\_(INITIAL HERE)

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Please note: This form must be signed prior to your initial consultation with your surgeon. Without this form, you will not be able to continue in the KC Bariatric Program.

*By signing this agreement, I am acknowledging my understanding of the Program Fee and my intention to follow through with the arranged payment plan.*

\_\_\_\_\_  
**Patient or Authorized Representative Signature**

\_\_\_\_\_  
**Patient (and Authorized Representative) Name Printed**

\_\_\_\_\_  
**Patient's Date of Birth**

\_\_\_\_\_  
**Today's Date**

**Current Medical Care**

To expedite the process of new patient information and to give our physician(s) an opportunity to review your current medical condition(s) and case, please be sure to **FULLY COMPLETE** each question in the current medical care section.

**Primary Care Physician & Preferred Pharmacy**

PCP Name: \_\_\_\_\_ Degree: \_\_\_\_\_  
 Address: \_\_\_\_\_ Suite: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Years of Care: \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_ Location: \_\_\_\_\_

**Current Prescription Medication List**

Medication Name	Dose	Frequency	Purpose	Date Started

**Current Non-Prescription Medication List**

Vitamin / Mineral / Item Name	Dose	Frequency	Purpose	Date Started

**Medication & Substance Allergies**

Allergic Substance Name	Reaction to Substance
<input type="checkbox"/> No Known Drug Allergies (NKDA)	<input type="checkbox"/> Latex Allergy

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Medical History for Bariatric Surgery

To expedite the process of new patient information, please be sure to **FULLY COMPLETE** each question in the medical history section. Answers should be accurate and honest, as inaccurate or incomplete answers may *delay our ability to process new patient intake &/or obtain insurance authorization.*

### Disease History

How many years have you been overweight? \_\_\_\_\_ How many years have you been trying to lose weight? \_\_\_\_\_

How long have you been researching or thinking about weight loss surgery? \_\_\_\_\_ Research Source: \_\_\_\_\_

### Past Medical History Assessment

Please answer all questions about your current &/or past history. Mark an "X" beside Yes or No for **every** question.

#### CARDIOVASCULAR

**YES**

**NO**

**Physician Notes (Office Use Only)**

High Blood Pressure	_____	_____	_____
Congestive Heart Failure	_____	_____	_____
Ischemic Heart Disease	_____	_____	_____
Heart stress test	_____	_____	_____
Heart attack	_____	_____	_____
Stents placed in Heart	_____	_____	_____
Heart catheterization	_____	_____	_____
Angina chest pain	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Stroke	_____	_____	_____
Lower Leg Edema / Swelling	_____	_____	_____
Blood clot in leg or lung	_____	_____	_____
Vena Cava heart filter	_____	_____	_____

#### METABOLIC

**YES**

**NO**

**Physician Notes (Office Use Only)**

Diabetes Mellitus, Type 1	_____	_____	_____
Diabetes Mellitus, Type 2	_____	_____	_____
Fasting Glucose > 99 mg/dL	_____	_____	_____
Oral medication for Diabetes	_____	_____	_____
Insulin use	_____	_____	_____
Eye / Kidney problems	_____	_____	_____
High Cholesterol or Lipids	_____	_____	_____
Gout / High Uric Acid levels	_____	_____	_____
Thyroid	_____	_____	_____

#### PULMONARY

**YES**

**NO**

**Physician Notes (Office Use Only)**

Oxygen use at home	_____	_____	_____
Pulmonary Hypertension	_____	_____	_____
Asthma	_____	_____	_____
Inhaler use due to Asthma	_____	_____	_____

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

# THE **Bariatric Center** OF KANSAS CITY

**Past Medical History Assessment** *(continued)*

**GASTROINTESTINAL**

	<b>YES</b>	<b>NO</b>	<b>Physician Notes (Office Use Only)</b>
Heartburn / Reflux / GERD	_____	_____	_____
Heartburn medication use	_____	_____	_____
Past anti-reflux surgery	_____	_____	_____
Barrett's Esophagus	_____	_____	_____
Crohn's Disease or Colitis	_____	_____	_____
Gallstones	_____	_____	_____
Gallbladder removal	_____	_____	_____
Abnormal liver tests	_____	_____	_____

**MUSCULOSKELETAL**

	<b>YES</b>	<b>NO</b>	<b>Physician Notes (Office Use Only)</b>
Back Pain	_____	_____	_____
Back Pain requiring medication	_____	_____	_____
Hip / Knee / Ankle pain	_____	_____	_____
Joint pain requiring medication	_____	_____	_____
Fibromyalgia	_____	_____	_____
Joint replacement	_____	_____	_____
Back surgery	_____	_____	_____

**REPRODUCTIVE** ( female )

	<b>YES</b>	<b>NO</b>	<b>Physician Notes (Office Use Only)</b>
Polycystic Ovarian Syndrome	_____	_____	_____
Infertility	_____	_____	_____
Menstrual irregularities	_____	_____	_____
Hysterectomy	_____	_____	_____

**GENERAL**

	<b>YES</b>	<b>NO</b>	<b>Physician Notes (Office Use Only)</b>
Stress urinary incontinence	_____	_____	_____
Sanitary pad use for leakage	_____	_____	_____
Pseudo tumor Cerebra	_____	_____	_____
Abdominal hernia	_____	_____	_____
Hernia repair	_____	_____	_____
Cane / Walker use	_____	_____	_____
Sores / rash in skin folds	_____	_____	_____
Previous weight loss surgery	_____	_____	_____
MRSA	_____	_____	_____
VRE	_____	_____	_____
Lupus / Autoimmune disease	_____	_____	_____

**PSYCHOLOGICAL**

	<b>YES</b>	<b>NO</b>	<b>Physician Notes (Office Use Only)</b>
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Bipolar disease	_____	_____	_____
Thoughts of suicide	_____	_____	_____
Suicide attempts	_____	_____	_____
Psychiatric treatment	_____	_____	_____
Psychological counseling	_____	_____	_____
Hospitalized for psychological issue(s)	_____	_____	_____

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_



## Sleep Testing Assessment

Testing for Sleep Apnea may be required to obtain clearance for bariatric surgery. Please be sure to **FULLY COMPLETE** each question in this section. Answers should be **accurate**, as inaccurate or incomplete answers may delay our ability to process &/or obtain insurance authorization.

### Sleep Testing & Treatment

\* Have you had a previous sleep study?  Yes  No

If yes, approximately when & where: \_\_\_\_\_

\* Have you had a prior diagnosis of Sleep Apnea?  Yes  No

\* Do you currently use PAP therapy?  Yes  No

If yes:  CPAP  BiPAP  AutoPAP  Other: \_\_\_\_\_ Pressure: \_\_\_\_\_ cm H2O

\* Who is your current Sleep Medicine Physician? \_\_\_\_\_

\* Who provider your PAP therapy and supplies? \_\_\_\_\_

Notes: \_\_\_\_\_

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

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### Family Medical History Assessment

Please mark any condition(s) that have been diagnosed in biological relation(s) such as parents, grandparents, siblings. Please check all that apply:

- |  |                                 |   |                                   |
|--|---------------------------------|---|-----------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Cancer | <input type="checkbox"/> Clotting Disorder            | <input type="checkbox"/> Diabetes |

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Physical Exercise Assessment**

Do you have any physical limitation(s) that make physical exercise difficult or impossible?  Yes  No  Sometimes

If yes, please explain: \_\_\_\_\_

Do you have difficulty with basic mobility or self-care?  Yes  No Do you use assistive devices to transport?  Yes  No

Devices currently used (check all that apply):  Cane / Walker  Wheelchair / Scooter  Crutches / Brace  Prosthetic Device  Oxygen

History of falls within last 12 months:  Yes  No How did it happen? \_\_\_\_\_

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**Social Assessment**

Do you use tobacco products / nicotine?  Yes  No Have you used tobacco products / nicotine in the past?  Yes  No

If Yes, type of tobacco / nicotine:  Cigarettes / \_\_\_\_\_ packs per day  Chewing tobacco  Smokeless tobacco / vaping

Tobacco Use ( frequency ):  Rare ( 1-2 times / month )  Occasionally ( 3 or less / week )  Frequently ( 4+ / week or daily )

Have you quit using tobacco products / nicotine?  Yes  No If yes, what / when was your quit date? \_\_\_\_\_

Do you use alcohol?  Yes  No If yes, what type? \_\_\_\_\_

Alcohol Use ( frequency ):  Rare ( 1-2 times / month )  Occasionally ( 3 or less / week )  Frequently ( 4+ / week or daily )

Do you recreationally use drugs / medication(s) / substance(s)?  Yes  No Have you used in the past?  Yes  No

If yes, what type? \_\_\_\_\_

Recreational Drug Use ( frequency ):  Rare ( 1-2 times / month )  Occasionally ( 3 or less / week )  Frequently ( 4+ / week or daily )

Have you quit using recreational drug(s)?  Yes  No If yes, what / when was your quit date? \_\_\_\_\_

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**Past Surgical History**

SURGERY	METHOD ( Note if done laparoscopically )	DATE	PHYSICIAN / LOCATION

Please list ANY OTHER medical problem(s) / surgical procedure(s) not listed in the Past Medical History Assessment: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Diet History

Please fill out the diet history form completely, with as much detail as possible. The information on this form is used for your Medical Necessity letter that is submitted to your health insurance provider. Documentation should reflect ALL weight loss efforts attempted, including but not limited to the following: Doctor Supervised, commercial programs, prescription diet pills, behavior modification, unsupervised diets and over-the-counter diet aides.

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### Weight History

Please provide your highest weight, each year, in pounds:

2012 \_\_\_\_\_ 2013 \_\_\_\_\_ 2014 \_\_\_\_\_ 2015 \_\_\_\_\_ 2016 \_\_\_\_\_

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### History of Diet Program(s)

PROGRAM	DATE RANGE	DURATION	DOCTOR SUPERVISED	TOTAL WEIGHT LOSS
Acupuncture			YES / NO	
Alli			YES / NO	
Anorexia			YES / NO	
Atkins			YES / NO	
Beverly Hills Diet			YES / NO	
Bulimia / Purging (after eating)			YES / NO	
Doctor Supervised Diet(s)			YES / NO	
Fen-Phen / ReDux			YES / NO	
Grapefruit Diet			YES / NO	
Jenny Craig			YES / NO	
Low-Fat Diet			YES / NO	
Meridia			YES / NO	
Metabolife			YES / NO	
Nutri-System			YES / NO	
O. A.			YES / NO	
OptiFast / MediFast			YES / NO	
Pritikin			YES / NO	
South Beach Diet			YES / NO	
T.O.P.S.			YES / NO	
Weight Watchers			YES / NO	
Zone Diet			YES / NO	

Additional Diet Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_