ORLANDO HEALTH® | Medical Group
89 W. Copeland Dr., 1st Floor, MP 820 • Orlando, FL 32806
tel (321) 843-8900 • *fax* (321) 843-8916 | OrlandoHealth.com

LINE UP PATIENT I.D. LABEL HERE

WELCOME TO ORLANDO HEALTH WEIGHT LOSS AND BARIATRIC INSTITUTE

Do I qualify for surgery?

- To qualify your BMI should be:
  40 BMI or greater without a medical condition (unless insurance requires it for authorization), or
  35-39 BMI with hypertension, sleep apnea, diabetes or coronary artery disease medically diagnosed.
  Calculate your BMI at http://www.bmi-calculator.net
- Age requirement 15-69 years old

Weight Category	BMI (kg/m²)
Healthy Weight	18.5-24.9
Overweight	25-29.9
Obese	30-34.9
Severely Obese	35-39.9
Morbidly Obese	≥40

Weight (lbs) \ Height (ft/in)	4'9"	4'11"	5'1"	5'3"	5'5"	5'7"	5'9"	5'11"	6'1"	6'3"
154	33	31	29	27	26	24	23	22	20	19
165	36	33	31	29	28	26	24	23	22	21
176	38	36	33	31	29	28	26	25	23	22
187	40	38	35	33	31	29	28	26	25	24
198	43	40	37	35	33	31	29	28	26	25
209	45	42	40	37	35	33	31	29	28	26
220	48	44	42	39	37	35	33	31	29	28
231	50	47	44	41	39	36	34	32	31	29
243	52	49	46	43	40	38	36	34	32	30
254	55	51	48	45	42	40	38	35	34	32
265	57	53	50	47	44	42	39	37	35	33
276	59	56	52	49	46	43	41	39	37	35
287	62	58	54	51	48	45	42	40	38	36
298	64	60	56	53	50	47	44	42	39	37
309	67	62	58	55	51	48	46	43	41	39
320	69	64	60	57	53	50	47	45	42	40

List of insurances we do not accept:

• Amerigroup	• Molina Healthcare
• Cigna Orange County Employees plan has exclusion	• BCBS member ID starting with VM plan has exclusion
• Advent Health Insurance	• Prestige
• HCA Insurance Plans	• Staywell and Wellcare
• Medicaid, Share of Cost, Staywell, Prestige, etc.	• Any limited benefits plans
• Sunshine Health	• Ambetter, OSCAR, Bright Health

Will my insurance cover bariatric surgery?

To verify if you have bariatric coverage call the member service phone number located on the back of your insurance card. Ask the representative if you have coverage for the diagnosis of morbid obesity (diagnosis code is E66.01) and if you have bariatric surgery coverage (procedure code may be 43775-Sleeve, 43644-Gastric Bypass, 43845 Duodenal Switch). If you have an HMO plan and/or need specialist referrals please reach out to your PCP, your referral will be needed prior to scheduling. ***We do not perform Lap Band placements or band adjustments, we only remove them.*** **Please complete the information below pertaining to your call with your insurance company. Orlando Health team members must have active insurance coverage for 1 year after your 90 day start date.**

Insurance Representatives Name: _____

Call Reference Number: _____ Do you have bariatric coverage? ☐ Yes ☐ NO

If your insurance does not cover bariatric surgery we offer self pay pricing, the initial visit fee is $250.00.

Once we receive your new patient packet our new patient coordinator will call you to schedule an appointment.

Please bring your driver's license and insurance card and come prepared to pay your specialist visit co-pays or co-insurance. If you are unable to pay the day of service we will need to reschedule your visit.

Office Locations

Orlando, Osceola and Leesburg

Email R-Bariatric@OrlandoHealth.com or fax to (321) 843-6472

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Print all information and use legal name printed on your insurance card.

Height: _____ **Weight:** _____ **BMI:** _____ ***Use page 1 to calculate body mass index or Go to http://www.bmi-calculator.net**

Legal Name: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth: _____ Sex: ☐ M ☐ F Social Security #: _____

Home Number: _____ Cell Number: _____

Email: _____

Emergency contact: _____ Phone: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Employer Name: _____ Occupation: _____ Phone: _____

Spouse's Name: _____ Date of birth: ____/____/____ Phone: _____

Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Address: _____
Street City State Zip

Insurance Information

Primary Insurance

Insurance Carrier: _____ Policy #: _____

Group #: _____ Provider Phone Number: _____

Insurance website located on the back of your card: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to patient: _____

Secondary Insurance

Insurance Carrier: _____ Policy #: _____

Group #: _____ Insurance Phone Number: _____

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Past Medical History

Do you currently or have you ever had any of the following conditions? Please mark YES or NO & list the year the event or diagnosis occurred. You may also add any additional information in the COMMENTS sections.

If there is more than one option in a row, circle the one that applies.

	Yes	*No*	*Year*	*Comments*
Cardiovascular Disease	☐	☐		
DO YOU CURRENTLY SEE A CARDIOLOGIST?	☐	☐		
High Blood Pressure	☐	☐		
Congestive Heart Failure	☐	☐		
Heart Disease	☐	☐		
Heart catheterization	☐	☐		
Stress test	☐	☐		
Date of last stress test?	☐	☐		
Date of last echocardiogram?	☐	☐		
Date of last EKG?	☐	☐		
Cardiac stent	☐	☐		
Heart Attack	☐	☐		
Angina	☐	☐		
Leg Swelling	☐	☐		
Blood Clots *location:* ☐ *arm OR* ☐ *leg OR* ☐ *lung* (***circle one***)	☐	☐		
Heart Murmur	☐	☐		
Irregular Heart Beat/Palpitations?	☐	☐		
Varicose Veins	☐	☐		
Have you ever seen a cardiologist?	☐	☐		***We will need records***
Have you ever had any complication with anesthesia?	☐	☐		
Metabolic Disease	☐	☐		
Diabetes	☐	☐		
High Cholesterol	☐	☐		
High Triglycerides	☐	☐		
Gout	☐	☐		
Thyroid Disease ☐ *Hypo* OR ☐ *Hyper (circle one)* ☐ Goiter OR ☐ Nodules (circle all that apply)	☐	☐		
Respiratory Disease	☐	☐		
Obstructive Sleep Apnea	☐	☐		
When was your last sleep study?	☐	☐		
Do you use ☐ *CPAP OR* ☐ *BiPAP ?* ***Circle One***	☐	☐		
Do you use O2? ☐ *All the time OR* ☐ *just at night?* ***Circle One***	☐	☐		
Shortness of breath? When does it occur? ☐ *Rest OR* ☐ *activity OR* ☐ *both* (***circle all that apply***)	☐	☐		
Asthma	☐	☐		
Emphysema	☐	☐		
	Yes	*No*	*Year*	*Comments*
Chronic Bronchitis	☐	☐		
Sarcoidosis	☐	☐		
Gastro-Intestinal Disease	☐	☐		
Gastro-Esophageal Reflux (GERD)	☐	☐		
Gallbladder disease	☐	☐		
Liver Disease - *please give details*	☐	☐		
Ulcers - *please give details*	☐	☐		
Diverticulosis	☐	☐		
Irritable Bowel Disease Was this diagnosed by a physician?	☐ ☐	☐ ☐		
Crohn's Disease	☐	☐		

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	Yes	No	Year	Comments
Musculoskeletal Disease	☐	☐		
Back Pain	☐	☐		
Fibromyalgia	☐	☐		
Arthritis (location: _____)	☐	☐		
Reproductive Disease	☐	☐		
PCOS (Polycystic Ovarian Syndrome)	☐	☐		
Menstrual Irregularities	☐	☐		
Genitourinary	☐	☐		
Stress urinary incontinence	☐	☐		
Frequent urinary tract infections	☐	☐		
Urinary Retention	☐	☐		
Kidney Stones	☐	☐		
Kidney Disease - *Please give details*	☐	☐		
Kidney Failure - *Please give details*	☐	☐		
Neurologic Disease	☐	☐		
Pseudo tumor Cerebri	☐	☐		
Frequent headaches OR dizziness	☐	☐		
☐ Strokes OR ☐ TIA's - (**circle one**) *Please give details*	☐	☐		
Neuropathy OR Numbness - *Where?*	☐	☐		
Psychological *(Circle all that apply)*	☐	☐		
☐Depression /☐Anxiety /☐Bipolar /☐Psychosis / ☐Personality Disorder /☐Suicidal Thoughts / ☐Bulimia /☐Anorexia (**circle all that apply**)	☐	☐		
Other (*Give specifics for all YES answers.*)	☐	☐		
Hernia	☐	☐		Type? Where?
Do you use a☐cane or a☐wheel chair? (Circle one)	☐	☐		
Do you have areas of large hanging skin? Where?	☐	☐		
Skin Disorders (☐ psoriasis /☐eczema / ☐acne / ☐dermatitis) (**circle all that apply**)	☐	☐		
	Yes	**No**	**Year**	**Comments**
Autoimmune disease (☐lupus /☐multiple sclerosis /☐etc.) (**circle all that apply**)	☐	☐		
☐ Bleeding OR ☐ clotting disorders (**circle one**)	☐	☐		
Cancers - *Please give details*	☐	☐		
Infectious disease ☐ HIV ☐TB ☐Hepatitis (circle all that apply) Treatment?	☐	☐		
Anemia ☐ B12 deficiency /☐iron deficiency /☐other (**circle all that apply**)	☐	☐		

PLEASE GIVE DETAILS OF ANY MAJOR ILLNESS OR MEDIAL ISSUE NOT ALREADY ADDRESSED ABOVE:

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SURGERIES/HOSPITALIZATION	**Dates**
Example - Tonsillectomy	*1993*

ALLERGIES: ARE YOU ALLERGIC TO **LATEX:** ☐ YES ☐ NO

Allergies	**Reaction**

SOCIAL HISTORY (tobacco & alcohol):

Do you now or have you ever smoked: ☐ YES ☐ NO How many years did you or have you smoked? _____

How many packs per day did you or do you smoke? _____ When did you quit? _____

Have you/do you use (d): ☐ pipe ☐ cigar ☐ e-cigarette ☐ illegal drugs-specify _____

Do you drink alcohol? ☐ YES ☐ NO Please list the type and frequency: _____

Have you ever experienced a drug/alcohol dependency? ☐ YES ☐ NO

Give Details: _____

Family History (please check if applicable)

	Father ☐ living	Mother ☐ living	Brother/Sister	Child
History of anesthesia complication				
Diabetes				
Heart Disease				
High Cholesterol				
Hypertension				
Obesity				
Sleep Apnea				
Asthma				
Osteoporosis				
Blood Clot				
Stroke				

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Patient Pharmacy and Medication Information (please include birth control/weight loss medications)

Pharmacy Name	Pharmacy Address	Phone/Fax
		T: _____ F: _____

Medication	Dosage	Frequency

COMMUNICATION ASSISTANCE PROVIDED (Please Print)		
QUALIFIED INTERPRETER	**QUALIFIED BILINGUAL TEAM MEMBER**	**ASSISTING VISUALLY IMPAIRED**
Team Member Name & I.D.: _____ Agency/Interpreter Name and/or I.D.: _____ ☐ Video remote ☐ Tel ☐ In-person Language: _____	Team Member Name & I.D.: _____ Language: _____	Team Member/Reader Name & I.D.: _____ Other: _____

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