NEW YOU
SURGICAL WEIGHT LOSS

Patient Registration

(Last Name) (First Name) (M.I.) (Preferred Name)

Birth Sex: ☐ Male ☐ Female Date of Birth: ___/___/_____ Social Security #: _____-____-_____

(Street Address) (City) (State) (Zip)

Ethnicity: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other | Marital Status: Single

Phone #: _____ Email Address: _____

Alt. Phone #: _____ Alias/Previous Name(s): _____

EMERGENCY CONTACT	
Name:	Emergency Contact's Phone #:
Relationship to patient:	Address:

Are you currently employed? ☐ No ☐ Yes, occupation: _____

☐ Full-time ☐ Part-time ☐ Volunteer

Employer Name: _____ Employer Phone Number: _____

How did you hear about our program?

☐ Word of mouth / Friend or family member ☐ Referred by a medical provider

☐ Google ☐ Social Media (or more specifically): ☐ Facebook ☐ Instagram ☐ TikTok

Further details (optional): _____

Primary Care Provider – Please provide your PCP's information below:

(Provider Name) (Phone Number)

(Clinic Name) (City) (State)

Other medical providers who currently treat you? Please provide details.

(Specialist Name) (Specialty) (Phone)

(Specialist Name) (Specialty) (Phone)

(Specialist Name) (Specialty) (Phone)

Preferred Pharmacy (& Location): _____

Preferred Lab Testing (& Location): _____

ALLERGIES	REACTION

MEDICATIONS
Please list **ALL** current medications below (including supplements):

HEALTH HISTORY			
Have you *ever* been diagnosed with any of these medical problems? Please add details in the space provided.			
			Details
High Blood Pressure	☐Yes	☐No	
Congestive Heart Failure	☐Yes	☐No	
Heart Attack	☐Yes	☐No	
Chest Pain related to your heart (or "Angina")	☐Yes	☐No	
Heart Catheterization	☐Yes	☐No	
Stroke	☐Yes	☐No	
Blood clots in your legs or lungs (i.e., DVT or PE)	☐Yes	☐No	
Gout	☐Yes	☐No	
Lower Extremity Swelling	☐Yes	☐No	
Diabetes or High Blood Sugars	☐Yes	☐No	
High Cholesterol	☐Yes	☐No	
Hyperthyroidism / Hypothyroidism	☐Yes	☐No	
Depression, Bipolar, Anxiety Disorder	☐Yes	☐No	
Snoring	☐Yes	☐No	
Sleep Apnea	☐Yes	☐No	
Pulmonary Hypertension	☐Yes	☐No	
Asthma	☐Yes	☐No	
Back or Leg Pain requiring treatment	☐Yes	☐No	
Disorder similar to Lupus or Rheumatoid Arthritis	☐Yes	☐No	
Barrett's Esophagus	☐Yes	☐No	
Crohn's Disease or Ulcerative Colitis	☐Yes	☐No	
Heartburn, Reflux, GERD	☐Yes	☐No	
Gastroparesis	☐Yes	☐No	
Liver disease or Abnormal Liver Test	☐Yes	☐No	
Hepatitis B or Hepatitis C	☐Yes	☐No	
Gallbladder Problems	☐Yes	☐No	
Polycystic Ovary Syndrome (PCOS)	☐Yes	☐No	
Urinary Stress Incontinence	☐Yes	☐No	
Are you on disability?	☐Yes	☐No	
Can you walk more than 200 ft without assistance?	☐Yes	☐No	

Do you use a wheelchair or walker for assistance?	☐Yes ☐No	
Are you on chronic Steroids (i.e. Prednisone)?	☐Yes ☐No	
Do you know of any problems with your kidneys?	☐Yes ☐No	
Are you currently prescribed blood thinners?	☐Yes ☐No	
Do you have HIV/AIDS?	☐Yes ☐No	
Do you take estrogen or testosterone supplements?	☐Yes ☐No	
Do you take oral contraceptives?	☐Yes ☐No	
Have you had postoperative nausea and vomiting in the past?	☐ Yes ☐No	
Are you on or expecting to go on dialysis?	☐ Yes ☐No	
Previous anesthesia complications?	☐ Yes ☐No	

SURGICAL HISTORY
☐ No previous surgeries | Have you had weight loss surgery before? ☐Yes ☐No
Please list any previous surgeries & when they were done:

FAMILY HISTORY						
Obesity:	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling	☐ Child	☐ Other:
Diabetes:	☐ Mother	☐ Father	☐ Grandparent	☐ Sibling	☐ Child	☐ Other:
Other (check all that apply):						
☐ High blood pressure	☐ High cholesterol	☐ High triglycerides	☐ Heart disease	☐ Stroke		
☐ Thyroid problems	☐ Cancer (type/s):					

SOCIAL HISTORY					
Do you use **ANY** nicotine products? Cigarette, vapor cigarette, smokeless tobacco, cigars, nicotine patches, nicotine gum, etc.					
☐ Never	☐ Yes, currently – Quantity:		☐ Yes, in the past – Quit Date:		
Do you consume alcohol? ☐ Yes ☐ No	If yes, what type?				
History of alcoholism? ☐ Yes ☐ No	History of prescription or non-prescription substance abuse? ☐ Yes ☐ No				
Highest Education Level:	☐ Grade school	☐ High school / GED	☐ College	☐ Post-grad	☐ Vocational tech
What level of activity does your job involve? ☐ Little (sedentary) ☐ Moderately active ☐ Very active (laboring, etc.)					

DIETING AND WEIGHT HISTORY

Please fill out as accurately as possible:	
Current Height: _____ in	**Current Weight: _____ lb**
Highest weight in the past year (lb)?	Lowest weight in the past year (lb)?
Highest adult weight (lb)? ←	When were you this weight?
Lowest adult weight (lb)? ←	When were you this weight?

What is the largest amount of weight you have lost on any one diet/medication? _____

Historically, have you ever used any of the following to control your weight? (check all that apply)

☐ Laxatives ☐ Diuretics ☐ Vomiting ☐ Binge eating then purging ☐ Binge eating followed by restriction

PAST DIETS/PROGRAMS/MEDICATIONS (check all that apply)			
☐ Ozempic/Wegovy	☐ Qsymia (phentermine/topiramate)	☐ Weight Watchers	☐ Nutrisystem
☐ Mounjaro	☐ Topamax (topiramate)	☐ Jenny Craig	☐ Keto
☐ Saxenda	☐ Wellbutrin (bupropion)	☐ Atkins	☐ Low-calorie diet
☐ Rybelsus	☐ Adipex (phentermine)	☐ Other (including supplements):	
☐ Lomaira (phentermine)	☐ Contrave (bupropion/naltrexone)		
☐ Phen-Fen	☐ Provider-supervised diet		

EATING HABITS (check all that apply)		
☐ Scheduled Regular Meals	☐ Grazer / No Set Schedule	☐ "Meat and Potatoes" Type
☐ Sweet Eater	☐ Binge eater/compulsive eater	☐ Junk Food Eater
☐ Large / Multiple Portions	☐ Emotional Eater	☐ Rapid Eater (meal in less than 10 min)

Do you plan meals in advance? ☐ Yes ☐ No	How many meals do you eat daily? 1
Do you ever skip meals? ☐ Yes ☐ No	If yes, which meals?
Do you ever have food cravings? ☐ Yes ☐ No	If yes, what foods do you crave?
How many snacks do you eat daily? 1	What are your favorite snacks?
Do you like to cook? ☐ Yes ☐ No	Do you often feel as if you need to "eat on the run"? ☐ Yes ☐ No
Who prepares your meals? _____	Who does the grocery shopping? _____
Do you get up at night to eat? ☐ Yes ☐ No	If yes, what do you eat when you get up?

(Check all that apply) Do you eat while:	☐ watching TV	☐ on the computer	☐ in bed	☐ in your car

Food Frequency Check:
Please indicate **how many times a week** you consume the following foods/beverages:

Fast food / Takeout:	Sit Down Restaurants:
Regular Soda:	Diet Soda?

EXERCISE HISTORY
How physically active are you? ☐ Very Active ☐ Active ☐ Average ☐ Inactive ☐ Very Inactive

Please list three things you hope to accomplish or ways your life will change by having surgery, or through medically supervised weight loss:

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

I have completed this entire demographic & medical questionnaire. All information has been accurately reported, to the best of my knowledge. I understand that falsifying, or failure to report, information could result in serious medical consequences and/or potential surgical complications should I undergo any procedures &/or operations.

Signature: _____ Date: _____

*** In addition to this registration form, please include a copy of your insurance card (if you have not done so already). ***

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SURGICAL WEIGHT LOSS

Patient Attendance Policy

Valued Patients,

Because appointments are in high demand, if for any reason you must cancel or change your scheduled appointment, it is important that you give our office at least **24 hours' notice** to offer that spot to someone else. Please call us at **314-887-7605.** We ask that you arrive 5 minutes early to fill out your visit paperwork.

Late Arrivals

When we reserve time for you, we require all that time to provide you with the best quality care possible. **If you arrive more than 10 minutes late for your appointment time, you may be required to reschedule** to meet the needs of those patients who are on time. We will check to see if there is anywhere to fit a late patient in our current day, however it is likely that patients will be rescheduled to a later date. In some cases, an appointment may not be available for several weeks.

No Shows and Cancellations Without 24 Hours' Notice

Missed appointments without 24 hours' notice create a hardship for everyone. Our providers' schedules are full, and in high demand. If you miss your appointment, you will be scheduled for the next available appointment, which may be weeks away.

For your convenience we provide reminder texts and calls 48 business hours prior to a scheduled appointment. The patient service representative (PSR) will leave a voice message indicating the date, location, and time of the patient's appointment. It is the responsibility of the patient receiving the voicemail to confirm, cancel, or reschedule 24 hours prior to the scheduled appointment. If the patient's phone is "out of service", not receiving calls, or has a full voicemail, the patient is still responsible for keeping the scheduled appointment.

It is our policy that patients with 2 No Show appointments or 3 cancellations without 24 hours' notice will have all future visits with our office cancelled.

We are a comprehensive program and attendance to your regularly scheduled appointments is critical to your success in meeting your weight loss goals. If you are on medications that need refills, missing appointments may affect your ability to obtain a refill in a timely matter.

☐ **By checking this box, I acknowledge that I have read, understand, and agree to the above outlined patient attendance policies.**

NEW YOU
A LIFE-CHANGING EXPERIENCE

HIPAA Privacy and Release of Information Authorization

I, hereby authorize New You Surgical Weight Loss and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature