SURGICAL ASSOCIATES
AT VIRGINIA HOSPITAL CENTER

BARIATRIC NUTRITION ASSESSMENT FORM

Today's date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Birth Date: / /	Age:	Gender: ☐ Male ☐ Female

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	E-mail:

Street Address:	Apt:	City:	State:	Zip code:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )

Occupation:	Employer:	Employer Phone No.: ( )

In Case of Emergency, Contact:	Relationship:	Emergency Contact Number: Cell/Home: ( ) Work: ( )

INSURANCE INFORMATION

Full Name of Insured (if other than patient):

Primary Insurance:	Group no.:	Policy no.:
Secondary Insurance (if applicable):	Group no.:	Policy no.:

VISIT INFORMATION

Weight Loss Surgery Being Considered ☐ Gastric Banding ☐ Sleeve Gastrectomy ☐ Roux-en-Y Gastric Bypass

Referring Physician:	Office no.:
Primary Care physician:	Office no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Associates at Virginia Hospital Center or insurance company to release any information required to process my claims.

Patient/Guardian signature ____________________ Date ____________________

Name: ____

WEIGHT HISTORY			
Height:	Current Weight:	Goal Weight:	
Heaviest Weight:	When?	Lowest Adult Weight:	When?

Do You have a history of:

Anorexia	
Bulimia	

WEIGHT LOSS PROGRAMS

Weight Loss Program	Dates Attempted	Weight lost?	Weight gained?	MD/RD supervised?
Weight Watchers				
Jenny Craig				
Slimfast				
Special K				
Atkins				
Nutrisystem				
Hospital Based program				
Nutritionist				
Exercise program				
Diet pills				
Other				

CURRENT MEDICATIONS

Please list all medications you are currently taking.

MEDICAL HISTORY

Do you or your family has a history of:

Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Obesity	☐ Yes	☐ No

Other:

Name: ____

GENERAL NUTRITION HISTORY

Do you currently exercise?	☐ Yes ☐ No
If so, what is your routine?	
Do you have any food allergies/intolerances?	☐ Yes ☐ No
If so please list:	
Do you take any supplements/vitamins?	☐ Yes ☐ No
If so please list	
What would you like to achieve from visiting with me?	
Do you see any barriers to achieving this goal?	
How often do you eat fast food?	
How often do you eat at restaurants?	
How often do you eat fried foods?	
How often do you eat dessert (cookies, cake, candy, etc)?	
Please check the items you add to food: ☐ Butter ☐ Margarine ☐ Salad Dressing ☐ Oil ☐ Mayonnaise ☐ Other	
Please check the types of beverages you drink: ☐ Diet soda/tea ☐ Water ☐ Regular soda/tea ☐ Juice ☐ Iced tea ☐ Coffee ☐ Energy drinks ☐ Milk ☐ Other:	
How often do you consume alcoholic beverages?	
What type?	
What types of foods do you crave?	
Do you eat fruits/vegetables daily?	☐ Yes ☐ No
Do you eat cheese/yogurt/milk daily?	☐ Yes ☐ No
Do you eat daily ☐ meat ☐ poultry ☐ beans ☐ tofu ☐ nuts ☐ eggs	
What is the first item you consume each day?	

Name: ______________________________________

MEALS DESCRIPTION
Please describe in detail the following:
Breakfast
Lunch:
Dinner:
Snacks:

Name: ______________________________________

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

Please read the following office policies. We would like for you to read and sign accordingly. Thank you for choosing Surgical Associates at Virginia Hospital Center.

It is your responsibility to be aware of your insurance policy. Please provide us with a current insurance card at the time of check-in. You will be asked at all subsequent visits if your insurance and/or demographic information has changed. *If you fail to give our office your new insurance card, you may be responsible for the full office charge. You are required to pay any applicable co-pays or current balances at the time of check-in unless you have made prior arrangements with the Practice Administrator.*

Surgical Associates at Virginia Hospital Center is not responsible if you fail to obtain the required authorization. If a referral is required for your insurance, you - the patient - are responsible to obtain the referral prior to your visit from your Primary Care Physician. If you do not have the required referral at the time of your appointment, payment will be due at the time of service. If there are any issues regarding your appointment, we can reschedule your appointment at your convenience.

If you are not able to keep your appointment, please provide 1 (one) business day notice. Failure to provide appropriate notice will result in a $35 fee for the missed appointment. We understand that emergencies happen and will take into consideration before any chargers are applied to your account.

Surgical Associates at Virginia Hospital Center will make every attempt to ensure you are seen in a timely manner. However our surgeons are occasionally called to emergencies. This may delay your appointment or you may be asked to reschedule your appointment. We appreciate your patience and understanding.

I have read the above policy.

____
Patient Name

____
Signature of Patient (or Parent/Legal guardian)

____
Name of Parent/Legal Guardian (if applicable)

____
Date