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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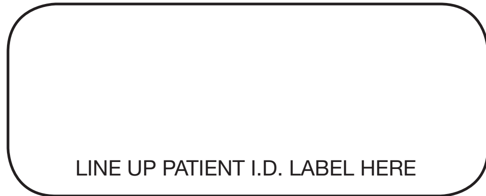

WELCOME TO ORLANDO HEALTH WEIGHT LOSS AND BARIATRIC INSTITUTE

Our Care Team Providers

Dr. Muhammad Jawad

Dr. Andre Teixeira

Dr. Muhammad Ghanem

Gayle Brazzi-Smith
Registered Nutritionist

Laura Rojas
Licensed Mental Health Counselor

Laura Committe
RN Care Coordinator

Certified Medical Assistants

Eliana
Elisha
Lucy
Rosie

Front Office

Anouskha
Diandra

Scheduling Coordinators

Angelee
Nanamaria
Roseanna

Insurance Coordinators

Doris
Millie
Ruth

Team Assist

Cathy

Surgery Scheduler

Carmen

Leader

Odalys Verdejo
Practice Supervisor

What to Expect During Your Visit

Front Office/Registration (15-20 minutes):

- Your name, date of birth, address, phone number and insurance information will be checked and updated.
- You will be asked to sign five consent forms to allow us to treat you today.

Nurse Care Team (10-15 minutes):

- We will take your height, weight, blood pressure and calculate your body mass index. A medical assistant may also review and update your current medicines and allergies for your safety.

We value your time.

We take wait times very seriously.

Our physicians will spend the necessary time with each and every patient.

Thank You

Care Provider (10-30 minutes):

- Your provider will review your medical history.
- Feel free to ask your provider questions about your health. Please remember to ask for any prescription refills you may need before your next visit.
- Your treatment plan and medicines will be updated.
- We are a teaching institution, during your visit you may see a resident or bariatric fellow.

We are a teaching institution, so a doctor completing their residency or fellowship may be involved in your care today.

Insurance Review (10-20 minutes):

- We will review your insurance requirements for authorization and preliminary testing.

We Want to Hear from You!

You may receive a satisfaction survey by email or mail. Please fill this out so we can hear what we're doing well and/or what we can improve. If you would like to speak with a manager today about your visit, please ask any member of our team. You can also phone the manager of this office directly at (321) 843-8905.

If you arrive more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available.

**Thank You for Choosing
Orlando Health Weight Loss and Bariatric Institute!**

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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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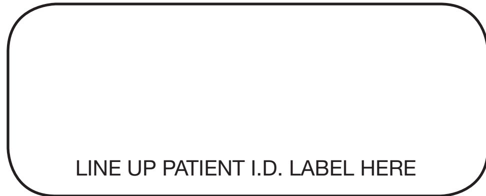

WELCOME TO ORLANDO HEALTH WEIGHT LOSS AND BARIATRIC INSTITUTE

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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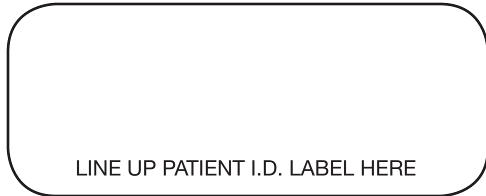

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SURGERIES/HOSPITALIZATION	Dates
Example - Tonsillectomy	*1993*

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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