Northside Bariatric Surgery Center
Paul Macik, M.D.
960 Johnson Ferry Road, Suite 228
Atlanta, Georgia 30342
Phone (404)252-2220 /Fax (404)252-4530

Patient Questionnaire Forms

Please Complete – All PAGES OF PAPER WORK

□ 1st sheet- Verify all info is correct and completely filled out, i.e. work numbers, insurance, address, and phone numbers etc.

□ 2nd sheet – Make sure to list all medications, surgeries and co-morbidities. Make sure all information is correct and complete.

□ 3rd sheet – Previous doctors with addresses and phone numbers.

We will start your preauthorization letter when we have received all required information. There is an application fee of $250.00. This is due when all information is ready to submit to your insurance company.

Once authorization has been received from the insurance company in writing we will then call you to schedule a surgery date.

Northside Bariatric Surgery Center, P.C.

Name: _____ _

Obesity Evaluation Form

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Procedure you are considering? ☐Lap Band ☐Gastric Bypass ☐Gastric Sleeve

Medical History

Allergies_____

Height_____ Weight_____ Ideal Body Weight_____

Previous Surgery & Date:

_____ _____

_____ _____

Medication & Dosage:

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Do you smoke?_____ Amount per day?_____
Alcohol? _____ Amount/How often?_____

WEIGHT RELATED ILLNESSES

Check if you have had the following illness:

☐High Blood Pressure
☐Diabetes
☐High Cholesterol or triglycerides
☐Sleep apnea
☐Do you use CPAP
☐Heartburn, hiatal, hernia, acid reflux
☐Choking or coughing at night
☐Gallbladder disease
☐ Liver Disease
☐Cancer
☐Polycystic Ovarian Syndrome
☐ Leakage of urine with coughing or straining
☐ Back Pain
☐Join problems in hip, knee, ankle or foot
☐Venous insufficiency or blood clots
☐Thyroid disease
☐Heart disease (Please Specify and Provide Records)
☐ Depression or psychiatric disorder (Please Specify and provide records)
☐Eating Disorder (Please Specify and Provide Records)

Patient Signature:_____ Date:_____

The above is true and correct to the best of my belief.

Northside Bariatric Surgery Center, P.C.

Name:_____

Obesity Evaluation Form

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Other medical illnesses (please list) or specific information related to heart disease, depression or psychiatric disorder, and/or eating disorder:

_____
_____
_____
_____
_____

List previous doctors seen for medical conditions/diet/control/etc.

Dr. Name_____Specialty_____
Address:_____
Phone #:_____ Fax #:_____

Dr. Name_____Specialty_____
Address:_____
Phone #:_____ Fax #:_____

Dr. Name_____Specialty_____
Address:_____
Phone #:_____ Fax #:_____

Dr. Name_____Specialty_____
Address:_____
Phone #:_____ Fax #:_____

Dr. Name_____Specialty_____
Address:_____
Phone #:_____ Fax #:_____

Patient Signature:_____ Date:_____
The above is true and correct to the best of my belief.