Mercer Health

Center for Healthy Weight & Wellness

Registration Packet

Mercer Health
Center for Healthy Weight & Wellness
830 W. Main St.
Coldwater, OH 45828
Phone: (419) 678-8446
Fax: (419) 678-5996

- ALL NEW PATIENTS MUST ARRIVE 30 MINUTES PRIOR TO APPOINTMENT TIME. FAILURE TO DO SO MAY RESULT IN RESCHEDULING OF APPOINTMENT.

Welcome to the Mercer Health Center for Healthy Weight & Wellness!

Mercer Health would like to thank you for choosing us as your health care team. Our goal and priority at the Center for Healthy Weight & Wellness Center is our patients' overall wellness. We provide comprehensive services to assist you in your journey towards a healthy weight and overall wellness. We recognize there are many facets to weight loss and weight management, so we have developed multidisciplinary programs and tools to assist you.

In order to provide you with the best possible service, we must have the following information on file before your appointment in the Center for Healthy Weight & Wellness. You may use this sheet as a checklist for your items.

- □ **The Center for Healthy Weight & Wellness Registration Packet:** Complete all forms and provide all necessary information to take the next steps in the program.
- □ **Medical and Prescription Insurance Cards and Driver's License:** Please bring any/all insurance cards along with your driver's license to your first appointment.
- □ **Medication Bottles/List:** To ensure we have the most up to date list of your current medications, please bring your medication bottles or a printed medication list you to your first appointment.

Prior to your appointment, it is pertinent that you contact your insurance company to verify Mercer Health is in network with your insurance, as well as if you have coverage for weight management/obesity services (ICD-10 Code: E66.01 and E66.9). After your initial consultation, we will verify your coverage and benefits for your specific weight management program.

Disclaimer: The Mercer Health Center for Healthy Weight & Wellness is not responsible for incorrect information that the insurance company may provide to you. Insurance verification does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges. Verification of benefits does not mean that you are approved for weight loss surgery. A surgical preapproval can only be obtained once the necessary documentation is sent to the insurance company by our team for pre-determination.

Please note that some insurance policies have contract exclusions which means that weight loss services will not be paid for even if it is medically necessary. Self-pay information is available by request. If you have questions regarding your insurance, please contact our team at 419-678-8446.

Please mail or drop off the completed packet to address:
Mercer Health Center for Healthy Weight & Wellness
830 West Main Street
Coldwater OH, 45828 **or**

Email to:
weightmanagement@mercer-health.com **or**

Fax to:
419-678-5996

Upon receipt of your New patient packet, you will be contacted by a member of The Center for Healthy Weight & Wellness team to schedule your first appointment.

We look forward to assisting you on your journey towards your healthy weight and overall wellness.
If you have any questions, please call our team at 419-678-8446.

Today's Date: _____

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: _____

City: _____ State: _____ Zip code: _____

Phone*: Home _____ Cell _____

Work _____

E-mail Address: _____

May we contact you via e-mail? ☐ Yes ☐ No

EMPLOYMENT INFORMATION

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled – if yes, provide reason _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip code: _____

INSURANCE INFORMATION

PRIMARY insurance: _____ Subscriber name: _____

Relationship to subscriber: ☐ Self ☐ Spouse ☐ Parent/Guardian

Member ID: _____ Group number: _____

Provider services phone number (found on back of card): _____

SECONDARY insurance: _____ Subscriber name: _____

Relationship to subscriber: ☐ Self ☐ Spouse ☐ Parent/Guardian

Member ID: _____ Group number: _____

Provider services phone number (found on back of card): _____

Please bring all insurance cards with you to your appointment including prescription card if applicable

PROVIDER INFORMATION

Primary Care Provider Name:	**Phone:**

Are you currently under the care of any other provider/providers:

Cardiologist: _____ Pulmonologist: _____

Endocrinologist: _____ Rheumatologist: _____

Psychiatrist/Psychologist: _____ Therapist/Counselor: _____

Orthopedic Surgeon: _____ Bariatric Surgeon/Weight Loss: _____

Gynecologist: _____ Other: _____

MEDICATION ALLERGIES:
FOOD ALLERGIES/SENSITIVITIES:

MEDICATIONS	
☐ **Prescription:**	☐ **Over the Counter / Herbal / Vitamins:**
Have you ever been prescribed? Wellbutrin/Bupropion: Yes No Topamax/Topiramate: Yes No Ozempic: Yes No Mounjaro: Yes No	

Previous or Current Injury	☐Fracture ☐Knee ☐Back (Cervical, Thoracic, Lumbar) ☐Shoulder ☐Other	☐Arm ☐Hand ☐Leg ☐Foot	☐Head ☐Neck ☐Eye
Previous or Current Illness			
Previous Surgeries (Please list)			

PERSONAL HISTORY

Have you ever been diagnosed with: (please circle if applicable)

Yes	No	
		Eating disorders (bulimia, anorexia)
		Diabetes (Type 1 or Type 2), Pre-Diabetes
		Medullary thyroid cancer
		High Blood Pressure (Hypertension)
		High cholesterol, triglycerides, or LDL
		Eye Problems (Decreasing Vision, Eye Pain, Double Vision, Vision Loss, Infection, Sensitivity to Light, Color Blindness, Eye Disease, Glaucoma, Wear glasses, Wear contact lens)
		Ear and/or Hearing Problems (Decreased Hearing, Pain or Ringing in the Ears, Ear Disorder)
		Heart Disease (Heart Attack, Bypass, Carotid stenosis, Peripheral artery disease, Chest pain, AAA)
		Pacemaker, Stents, Implantable Devices, Other Heart Procedures
		Mental Health Problems (Depression, Anxiety, Psychiatric and/or Nervous Disorders)
		Gastrointestinal Problems (GERD, Acid reflux, Gallbladder, Ulcers, Gastritis, Colitis, other Bowel Diseases)
		Lung Disease (Sleep apnea, CPAP, Bi-pap, Asthma, COPD, Emphysema, Chronic Bronchitis, Tuberculosis, Silicosis)
		Chronic (long-term) Cough, Shortness of Breath, Breathing Problems
		Stroke, Mini-Stroke (TIA), Paralysis or Weakness
		Dizziness (Vertigo), Frequent or Severe Headaches, Numbness, Tingling, Memory Loss
		Fainting, Loss of Consciousness
		Head/Brain Injuries and/or Illnesses (Concussion)
		Skeletal Problems (Arthritis, Gout, Rheumatism, Joint Pain or Swelling)
		Liver Disease (Fatty liver, NASH, Cirrhosis, Hepatitis A, B, C, D, E)
		Kidney Problems (Kidney Stones)
		Thyroid disorder (hypothyroidism, goiter, graves, hashimoto's thyroiditis, cancer)
		Seizures (Epilepsy)
		Neuromuscular Disorders (Multiple Sclerosis, Muscular Dystrophy, Cerebral palsy, Parkinson's disease)
		Blood Disease (DVT, Anemia, Hemophilia, Clotting Disorders, HIV)
		Varicose Veins
		Hernia or Rupture
		Chronic Skin Rash (Dermatitis, Eczema)
		Cancer (Tumor, Cyst)
		Prostate Disorder (Males)
		Gynecologic Disorder (Females), PCOS
		Current Pregnancy (Females)
		Are you currently trying to conceive (Females)
		Are you currently breast feeding (Females)
		Other Health Condition(s) not described above. Please describe.
		Did you answer "yes" to any of the above health conditions? Please comment below.

FAMILY HISTORY

Has any member of your family been diagnosed with Medullary thyroid cancer? Yes No

If yes, Who?

PERSONAL WEIGHT HISTORY

Highest Adult Weight: _____ Lowest Adult Weight: _____ Desired Weight: _____

My obesity started: ☐ As a Child ☐ At Puberty ☐ As an Adult ☐ After Pregnancy

Describe _____

When you gained weight, was there a life event?

- ☐ A habit change (quitting smoking, drinking, drug use)
- ☐ A move (New environment)
- ☐ Change in Family structure (married, separated, divorced, death)
- ☐ Career change
- ☐ A family change (having children, becoming an empty nester)
- ☐ An illness or diagnosis
- ☐ A financial issue

What was your greatest single weight loss in pounds? _____

How did you lose the weight?

- ☐ Physical activity ☐ Healthy eating ☐ Portion control
- ☐ Over-the-counter medication ☐ Prescription medication ☐ Surgery
- ☐ Nutritional counseling ☐ Social support ☐ Wasn't actively trying
- ☐ Other: _____

How long did you sustain that weight loss? _____

NUTRITION-RELATED HISTORY

Have you ever made yourself vomit after eating? ☐ Yes ☐ No
If yes, when was the last time you made yourself vomit after eating? _____

Have you ever used laxatives as a means of weight control? ☐ Yes ☐ No
If yes, when was the last time you took a laxative for weight loss? _____

Do you currently have any medical restrictions on your diet? ☐ Yes ☐ No
Describe: _____

Do you currently consume energy drinks? ☐ Yes ☐ No Quantity per day: _____

Do you currently consume soda/pop? ☐ Yes ☐ No Quantity per day: _____

How many ounces of water do you drink on a daily basis? _____

How many meals do you eat out per week? _____
Are these meals usually fast food? ☐ Yes ☐ No
Are the majority of these meals with family or friends? ☐ Yes ☐ No

Who does the cooking in your household? _____

Who does the grocery shopping for your household? _____How often? _____

Of the following, check all the items that explain or describe your eating:
☐ Eating high-fat fast foods ☐ Eating sweet foods ☐ Eating from emotions ☐ Over-eating when alone
☐ Using food as a reward ☐ Uncontrollable binges ☐ Eating quickly ☐ Eating to distract self
☐ Overeating when at social events
☐ Other (explain) _____

Do any of the following affect your choice of food:

☐ Finances ☐ Eating disorder ☐ Food restrictions/allergies
☐ Occupation/shift work ☐ Prescription drugs/vitamins/herbal supplements
☐ Eating when in public vs eating when alone
☐ Other, Explain: _____

List all foods and beverages you consumed in the last 24 hours:

Time food was consumed	Name and amount of food consumed

LIFESTYLE (Circle if applicable)

Smoking: Never Former Every Day Some Days Unknown **Passive exposure**: Yes No
Types: Cigarettes Pipe Cigar Current usage: 0.25 0.5 1 1.5 2 3
First smoked: _____ Quit date: _____

Smokeless/Chew: Never Former Current Unknown
Age started: _____ Quit date: _____ Current use (Cans per day) _____

E-Cigarette/Vaping: Never Former Every Day Some Days Unknown **Passive exposure:** Yes No
E-cigarette/Vaping Substances: Nicotine: Yes No CBD: Yes No Other: _____
E- cigarette/Vaping Devices: Disposable: Yes No Pre-filled or Refillable Cartridge: Yes No
Refillable Tank: Yes No Pre-filled Pod: Yes No

Alcohol Use: Yes Not Currently Never Comments: _____
Drinks per week: Glasses of wine _____ Cans of beer _____ Shots of liquor _____

Marijuana Use: Yes Not Currently Never
Types: Smoking Vaping Edibles

Drug Use: Yes Not Currently Never Use/week: _____ Comments: _____

Types: Opiates Amyl nitrate Anabolic steroids Barbiturates Benzodiazepines "Crack" cocaine Cocaine Codeine Fentanyl Flunitrazepam GHB Hashish Heroin Hydrocodone Hydrocodone Hydromorphine Ketamine LSD MDMA (ecstacy) Mescaline Methamphetamines Methaqualone Methylphenidate Morphine nitrous oxide Opium Oxycodone PCP Psilocybin Solvent Inhalants Other _____

Fitness/Exercise:

Do you participate in fitness/exercise activities? Yes No What type of activity? _____
Minutes per day? _____ Days per week? _____

Limitations:

Are you unable to participate in physical activity because of a disability or medical condition? Yes No
If yes, please describe _____
Do you consider yourself a fall risk? Yes No
Do you use an assistive device with ambulation? Yes No
If yes, what device do you use? _____

WEIGHT LOSS HISTORY

	# Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Medically Supervised Medications/Programs					
Phentermine/Adipex					
Qsymia					
Contrave					
Wegovy (Semaglutide)					
Zepbound (Tirzepatide)					
Optifast®					
Fen-Phen®					
Behavior Modification with physician or dietitian					
Hypnosis					
Chirothin					
Non-Medically Supervised Programs					
Weight Watchers®					
Nutrisystem®					
Jenny Craig®					
Optivia®					
Golo® or Noom®					
Alkaline diet					
Miscellaneous Diet Attempts					
Low Calorie Diet					
Low Fat Diet					
High Protein/Low Carb Diet (Atkins), Keto					
Self-Imposed Fasts/ Intermittent fasting					
Slim-Fast®					
Keto gummies					
Herbalife®					
Southbeach®					
Other attempts					

PERSONAL STATEMENT

Please tell us, in your own words, why you feel it is important to lose or manage your weight, the effects of weight on your health, employment, social life, etc, and why *now* is the right time for you.
Please use additional paper, if necessary.

I declare each of my answers to be full, complete and true to the best of my knowledge.
I understand that any false statement or misrepresentation in answering the above could cause my immediate discharge regardless of when such fact may be discovered.

Patient Signature: _____

Date: _____