



Dr. Stephen Sudderth, FACS

188 YMCA Place, Vicksburg, MS 39183 (o)601-636-7222 (f)601-636-0440

Dr. Stephen Sudderth and the entire staff of Premier Medical Weight Loss of Mississippi would like to welcome you to our clinic and look forward to meeting you on your first visit. Dr. Sudderth partners with each patient to develop a custom weight management program to best meet their individual needs. His programs take into account lifestyle, medical history, medications taken on a regular basis, special dietary needs and computerized body composition analysis.

To help you prepare for your first visit, please print out the new patient packet, complete all of the forms prior to your visit and bring them with you. If you do not have your forms with you on your first visit you will be required to complete them the morning of your appointment and your visit will take much longer than scheduled.

If you have any questions, please feel free to contact our office at 601-636-7222.

We look forward to meeting you!

Stephen Sudderth, MD, FACS

New Patient Form Checklist:

To Be Completed and Brought With You on Your First Visit:

- Patient Registration Form
- Patient Informed Consent for Appetite Suppressants
- Medical Weight Loss Program Consent Form
- Medical Weight Loss Consumer Bill of Rights
- Medical History Form



Stephen Sudderth, MD, FACS is a Board Certified, Recertified, and Fellow of the American College of Surgeons. He is one of the only practicing Fellows in Vicksburg, Mississippi. He has an active practice in General Surgery with a concentration in advanced laparoscopic procedures associated with General Surgery, as well as Bariatric Surgery. Currently, Dr. Stephen Sudderth is the only independent General Surgeon in Vicksburg.

Dr. Stephen Sudderth is also a Bariatrician. A bariatrician is a licensed physician who has received special training in bariatric medicine in the medical treatment of obesity and its associated conditions. While any licensed physician can offer medical weight loss to patients, Dr. Sudderth sets himself apart from other physicians through extensive medical education and training programs, acquisition of specialized knowledge, and tools and techniques. Because of his extensive training in the treatment of obesity, Dr. Sudderth offers the highest qualification to design individualized medical weight loss treatments tailored for each patient, in addition to offering life-long weight loss maintenance plans.

Dr. Stephen Sudderth and the entire staff at Premier Medical Weight Loss of Mississippi are committed to offering a comprehensive and individualized approach. Dr. Sudderth partners with each patient to develop a custom weight management program to best meet their individual needs. His programs take into account lifestyle, medical history, medications taken on a regular basis and also special dietary needs. With the help of his Registered, Clinical Dietician on staff in the clinic, Dr. Sudderth teaches each patient about a healthy approach to weight loss, while offering the very best strategies bariatric medicine has to offer. A very important part of the program is his partnership with the patients to achieve long term healthy eating habits through comprehensive dietary education, teaching about behavior modification and lifestyle changes to achieve long term success. In combination with reduced calorie diets, behavior modification, exercise and nutritional education, Dr. Sudderth is also able to prescribe FDA approved weight loss medication to eligible patients.

Premier Medical Weight Loss, unlike so many other “fad diets” and “gimmicky quick weight loss program” that offer unrealistic outcomes, Dr. Sudderth offers each patient a real life solution. Premier Medical Weight Loss receives a large number of referrals from satisfied patients, as well as referrals from Family doctors, Internal Medicine doctors, Cardiologist, and other physician specialties. Dr. Sudderth also works with employers to offer healthy weight management education and treatment for employees. Many of our patients come to our clinic with high cholesterol, high blood pressure, diabetes, and many other medical problems. Because of Dr. Stephen Sudderth’s extensive training in obesity, he is able to provide the best possible solution in the treatment of metabolic syndrome and obesity. At Premier Medical Weight Loss of Mississippi, we only partner with our patients for the metabolic syndrome and work with our patient’s primary physicians to ensure long term improved health of the associated health problems that accompany obesity.

Dr. Sudderth has an incredible passion and takes a personal stake in each one of his patients. Dr. Sudderth’s partnership with each patient to combat the chronic illness of obesity begins with the patient and ultimately perpetuates into the household. Because of his personal stake in each patient’s success, his efforts can be far reaching beyond the patient. What Premier Medical Weight Loss of Mississippi and Dr. Stephen Sudderth offers to his patients, the community of Vicksburg and entire state of Mississippi is truly an effort of passion to overcome obesity and attempt to make a difference. **If you have any questions about the Premier Medical Weight Loss of Mississippi and Dr. Sudderth, please feel free to contact us at 601-636-7222.**

Premier Medical Weight of Mississippi

Comprehensive Medical Weight Loss with compassion that counts

PATIENT REGISTRATION **All Information is Confidential**

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Patient Social Security #r _____ Drivers License: _____

Email address: _____

Date of Birth _____ Age: _____ Sex: M F

Country of Birth: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Emergency Contact

Relationship to Insured _____ First & Last Name _____

Home # _____ Work # _____ Cell # _____

Financial Policy

Thank you for selecting Dr. Stephen Sudderth for your Medical Weight Loss Management. We are honored to be of service to you and your family. Please be advised that payment of all services is due at the time services are rendered. We do not bill insurance, nor do we provide any information to insurance companies for any medical weight loss services rendered at Premier Medical Weight Loss of Mississippi. For your convenience, we accept Visa, MasterCard, Discover, cash or checks.

I have read and understand all of the above and have agreed to these statements.

HIPPA Policy

I understand the HIPPA policy is available in the office and on the clinic web site for all patients to review.

Signature (Patient or Parent of Minor) _____

Date _____

Stephen Sudderth, MD, FACS

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Notice of Personal Health Information Practices (HIPPA Privacy Notice)

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

Introduction: At Dr. Stephen Sudderth's office we are committed to treating information about you and your health responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective March 1, 2009, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information: Each time you visit Dr. Sudderth's a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

A basis for planning your care and treatment,

- A means of communication among many health professionals who contribute to your care,
- A legal document describing the care you received,
- A means by which you a third party can verify that services were actually provided,
- A tool in educating health professionals,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decision when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of Dr. Sudderth the information belongs to you. You have the right to:

- Inspect and copy your health record,
- Amend your health record,
- Obtain an accounting of disclosures of your health information,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

Dr. Sudderth is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to Report a Problem:

If you have questions and would like additional information, you can contact us at 601-636-7222.

Premier Medical Weight Loss of Mississippi

Comprehensive Medical Weight Loss with compassion that counts

Patient Informed Consent for Appetite Suppressants

I. Procedure & Alternatives:

1. I, (Name and Social Security #)_____ authorize Dr. Stephen Sudderth and whomever his designated Nurse Practitioner is, to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

“Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

“As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

“Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

“As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants.”

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient’s Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ **TIME:** _____

PATIENT: _____ **WITNESS:** _____

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient’s related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician’s Signature

Date

Premier Medical Weight Loss of Mississippi

Comprehensive Medical Weight Loss with compassion that counts

MEDICAL WEIGHT LOSS PROGRAM CONSENT FORM

I, (Name & SS#) _____ authorize Dr. Stephen D. Sudderth and whomever he designates as his assistant, to help me in my weight loss reduction efforts. I understand that my program consists of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet and/or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used the durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of the program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with the remaining overweight tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

Women Only: I understand that Phentermine or any other weight loss medication should not be taken during pregnancy, due to the chance of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on medication. If I become pregnant, I will advise both the clinic and my OB/GYN immediately.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, as your doctor now before signing this consent form.

Date: _____ Time: _____

Patient Signature: _____

Office Personnel / Witness: _____

MEDICAL WEIGHT LOSS CONSUMER BILL OF RIGHTS

Warning: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program that is not supervised by a physician specializing in medical weight loss management. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual and estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual estimated duration of the program.

I HAVE READ THE ABOVE STATEMENT ABOVE:

Patient's Signature: _____ Date: _____

Office Personnel / Witness _____ Date: _____

KNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____

Date: _____

By signing this form, you acknowledge that Dr. Sudderth's office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

If there are any individuals with whom we are permitted to share your medical information, please provide their names(s) here: _____

Patient's Signature: _____ Date: _____

Office Personnel / Witness _____ Date: _____

Patient Name: _____ DOB _____ Date _____

Dr. Sudderth and staff review all information carefully. Your entire history is important to us.

MEDICAL HISTORY

Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> History of Colon Cancer |
| <input type="checkbox"/> Edema (Swelling of Legs) | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Previous Stroke or Heart Attack | <input type="checkbox"/> Trouble Urination/ Male BPH |
| <input type="checkbox"/> Varicose veins or Venous Stasis | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> DVT or Pulmonary Embolus | <input type="checkbox"/> History of Prostate Cancer |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sexual Dysfunction/Low Sex Drive |
| <input type="checkbox"/> Snore | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Daytime drowsiness | <input type="checkbox"/> Eats Ice Frequently (PICA) |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Excess Facial Hair (Female) |
| <input type="checkbox"/> Use CPAP or BIPAP | <input type="checkbox"/> Abnormal Menstrual Cycle |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty becoming pregnant |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> COPD | <input type="checkbox"/> History of Breast Cancer |
| <input type="checkbox"/> Use of Home Oxygen | <input type="checkbox"/> History of Ovarian or Uterine Cancer |
| <input type="checkbox"/> Diabetes – Juvenile | <input type="checkbox"/> Hot Flashes/Night Sweats |
| <input type="checkbox"/> Diabetes – Adult Onset | <input type="checkbox"/> Trouble Falling Asleep |
| <input type="checkbox"/> Diabetes – Pregnancy | <input type="checkbox"/> Trouble Staying Asleep |
| <input type="checkbox"/> Always Thirsty | <input type="checkbox"/> Depression - New Onset |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Depression – Chronic |
| <input type="checkbox"/> Underactive Thyroid | <input type="checkbox"/> Bipolar Disease |
| <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Anxiety or High Stress |
| <input type="checkbox"/> Significant Hair Loss | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Pituitary Gland Disease | <input type="checkbox"/> Binge Eating |
| <input type="checkbox"/> Adrenal Gland Disease | <input type="checkbox"/> Bulimia or Purging |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anorexia Nervosa |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Arthritis/Osteoarthritis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Gallbladder diseases | <input type="checkbox"/> Need Assistance Walking |
| <input type="checkbox"/> Heart Burn/Reflux/GERD | <input type="checkbox"/> Numbness in Hands/Feet |
| <input type="checkbox"/> Chronic Constipation | |
| <input type="checkbox"/> Chronic Diarrhea | |

Any other medical or psychiatric problems not listed: _____

Patient Name: _____ DOB _____ Date _____

MEDICATIONS

List all of medications you currently take including vitamins, minerals and herbs, hormones, birth control pills.

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

ALLERGIES

Do you have any medical or food allergies? _____

PERSONAL PHYSICIAN

Do you have a primary care physician or an Internal Medicine doctor? Yes No

Primary Care Doctor's Name _____

City Located _____

PAST SURGICAL HISTORY

- Previous Surgeries: 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

OB/GYN HISTORY

Do you still have periods? Yes No

Have you had a Hysterectomy or tubal ligation? Yes No

Do you have regular monthly menstrual periods? Yes No

If no, explain: _____

Are your periods heavy? Yes No

How many days do your periods last? _____

Are you past menopause? Yes No

History of Miscarriages Yes No Ectopic Pregnancies Yes No Birth Control Yes No

FAMILY HISTORY

- Obesity High Cholesterol Diabetes
- Lung Disease/asthma/emphysema High blood pressure Kidney disease
- Heart Disease/stroke Bleeding disorder Cancer
- Psychiatric (depression, eating disorder, alcoholism)

Patient Name: _____ DOB _____ Date _____

SOCIAL HISTORY

Married Single Divorced Widowed

Number of children or grandchildren living with you? _____ Ages: _____

Have you ever smoked cigarettes? Yes No Amount: _____

If you have quit smoking, when did you stop? _____

History of drug abuse? Yes No Treatment? Yes No

History of alcohol abuse? Yes No Treatment? Yes No

How many hours do you typically sleep per night? _____

Occupation: _____ Working Hours: _____

Are you a student? Yes No If so, full time part time

Typical time you wake up _____ Typical time you go to bed: _____

Do you work overnight shift? Yes No

What time do you wake up & go to sleep when working overnight? _____

WEIGHT HISTORY

What is your high school graduation weight (age 18) _____

Marriage Weight _____ Desired Weight _____

When did you begin gaining excessive weight? _____

DIET HISTORY

Do you eat 3 meals/day? Yes No If not, how many? _____

Which meals do you commonly miss? _____

Do you graze throughout the day? Yes No

How many times do you eat out or pick something up to bring home? _____

Are you a night time eater? Yes No

If so what do you normally eat? _____

Are you a binge eater? Yes No

History of purging after you binge? Yes No

If yes, are you purging through exercise, vomiting, laxatives, or diuretics? _____

Do **you** do the majority of the grocery shopping? Yes No

Patient Name: _____ DOB _____ Date _____

Do **you** cook at home? Yes No Do you or other people think you eat too fast? Yes No Is your spouse, fiancée or partner overweight? Yes No Do you have any overweight children? Yes No

If you are a vegetarian, what foods will you not eat? _____

Have you used weight loss medications in the past? Yes No If yes name: _____

If you have taken weight loss medication in the past, how long ago did you take it? _____

If you have taken weight loss medication did you experience side effects? Yes No

If yes, please explain _____

If you have taken weight loss medication in the past, how much weight did you lose? _____

DO YOU DRINK:Sweet Tea made with **sugar**? Yes No If yes, Daily Few per week rarely**Regular** soft drinks? Yes No If yes, Daily Few per week rarelyFruit Juices? Yes No If yes, Daily Few per week rarelyHawaiian Punch? Yes No If yes, Daily Few per week rarelyKool Aid? Yes No If yes, Daily Few per week rarelyEnergy Drinks? Yes No If yes, Daily Few per week rarelyWhole Milk? Yes No If yes, Daily Few per week rarelyAlcohol? Yes No If yes, Daily Few per week Special Occasions

If yes, what type of alcohol do you drink? _____

Your diet history will be discussed during your initial visit. All efforts are relevant, even those with minimal or no weight loss. Please list all significant diet efforts for the past 5 years.

Name Of Diet	Year	Length of Effort	Weight Loss	Weight Regained