ADVANCED BARIATRIC CENTER

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~ The Path to a Healthier Lifestyle ~

Bariatric Surgery Patient Forms

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PATIENT REGISTRATION FORM

(please print)

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MISS. ☐ MS. PATIENT'S LAST NAME FIRST MIDDLE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOW	
IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO IF NOT, WHAT IS YOUR LEGAL NAME (FORMER NAME)?	BIRTH DATE / /	AGE	SEX ☐ M ☐ F
STREET ADDRESS:	SOCIAL SECURITY # 000 - 00 -	HOME PHONE ( )
CITY / STATE / ZIP:	EMAIL:	CELL PHONE ( )
OCCUPATION:	EMPLOYER:	WORK PHONE ( )

WHO REFERRED YOU TO OUR OFFICE (PLEASE CHECK ONE)? ☐ FAMILY ☐ FRIEND ☐ CLOSE TO HOME / WORK
☐ INTERNET ☐ DR. ______________________ ☐ INSURANCE PLAN ☐ HOSPITAL
☐ OTHER ____

PRIMARY CARE PHYSICIAN NAME/ADDRESS:

PREFERRED PHARMACY NAME AND CITY:

Race (please check one box): ☐ Caucasian ☐ Asian ☐ African-American ☐ Hispanic ☐ Hawaiian/Pacific Islander ☐ Prefer not to answer

Ethnicity (please check one box): ☐ Hispanic ☐ Non-Hispanic

INSURANCE INFORMATION

INSURANCE COMPANY #1	INSURED'S NAME	INSURED'S BIRTH DATE / /
INSURANCE COMPANY #2	INSURED'S NAME	INSURED'S BIRTH DATE / /

PERSON RESPONSIBLE FOR THE BILL:

IN CASE OF EMERGENCY

NAME:	HOME PHONE ( )
RELATIONSHIP TO PATIENT:	CELL PHONE ( )

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 ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

____ ______________________

PATIENT/GUARDIAN SIGNATURE DATE

Health History Form

Name: ______________________________ Date of Birth: ______________________________

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: ______________________________

Current Height: ______________ Weight: ______________ Other concerns: ______________________________

MEDICAL HISTORY

Have you ever had anesthesia? ☐ Yes ☐ No Did you experience any of the following:
☐ Airway problem? ☐ Malignant hypothermia (High fever during surgery?)

Do you smoke? ☐ Yes ☐ No How many packs per day? __________ How many years? ________

Do you consume alcohol? ☐ Yes ☐ No Quantity? __________ How often? ____________

Does your medical history include any of the following:

☐ Anemia ☐ Bronchitis ☐ Anemia ☐ High Blood Pressure
☐ Heart Attack ☐ Irregular Heart Beat ☐ Emphysema ☐ Stomach Ulcer
☐ Mitral Valve Prolapse ☐ Swelling in hands or feet ☐ Chest pain ☐ Arthritis
☐ Diabetes ☐ Hepatitis or jaundice ☐ Kidney problem ☐ Back pain or injury
☐ Thyroid problem ☐ Epilepsy or seizures ☐ Heart Pacemaker (please have card available)
☐ Tuberculosis ☐ Stroke ☐ Cancer (type) ______________________________
☐ Other ______________________________
____

MEDICATIONS:

Medication/Vitamin/Supplement	Dosage/Strength (e.g. mg/pill)	How many times Daily?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY	**MOTHER**	**FATHER**	**OTHER RELATIVE** (Please specify)
Cancer (type)	☐ ____________	☐ ____________	☐ ____________
Heart Disease	☐ ____________	☐ ____________	☐ ____________
Diabetes	☐ ____________	☐ ____________	☐ ____________
Stroke	☐ ____________	☐ ____________	☐ ____________
High Blood Pressure	☐ ____________	☐ ____________	☐ ____________
Other	☐ ____________	☐ ____________	☐ ____________

ALLERGIES: Do you have allergies or reactions to:

Medications	**Reaction**	**Foods**	**Reaction**

Please list other additional physicians:

Psychiatrist/Psychologist:____

Address:____

Phone:____Fax:____

Orthopedic:____

Address:____

Phone:____Fax:____

OB/GYN:____

Address:____

Phone:____Fax:____

How did you hear about our program?

☐ Friend ☐ Family ☐ Doctor ☐ TV ☐ Radio ☐ Newspaper ☐ Internet ☐ Other__________________________

What weight loss surgery are you interested in?

☐ Roux-en-Y Gastric Bypass ☐ Gastric Band ☐ Sleeve Gastrectomy ☐ Revision ☐ Unsure

Have you ever had bariatric surgery? ☐ Yes ☐ No

If yes, what surgery and when? ____

Habits:

Do you drink caffeine? ☐ Yes ☐ No
Type: ☐ Coffee (___ cups/day) ☐ Soda (___ cups/day) ☐ Tea (___ cups/day)

Do you use recreational drugs? ☐ Yes ☐ No
Type: ☐ Marijuana(___/week) ☐ Cocaine(___/week) ☐ Heroin(___/week) ☐ Other

Weight Loss History:

Height:________________________Weight:______________________BMI:________________________________

Highest Adult Weight:___________________________Lowest Adult Weight:____________________________________

My obesity started: ☐ in childhood ☐ at puberty ☐ as an adult ☐ after pregnancy
☐ after a traumatic event ☐ other ____

Additional notes regarding the onset of obesity:____
____
____

Taste Preferences:

☐ Sweet ☐ Salty ☐ Fast Food ☐ Comfort Foods ☐ Other ___________________________

Eating Habits:

☐ Binge Eater ☐ Night Eater ☐ Grazer/Snacker ☐ Emotional Eater

Do you: ☐ Over Eat ☐ Over Indulge ☐ Binge Eat?

(Over eating is when you plan to eat a normal amount and you overeat but not to the point of feeling like you may vomit. Over indulgence is when you plan to eat too much but not to the point of wanting to vomit. Binge eating is defined as eating a large amount of food during a short period of time, typically no more than 2 hours, while feeling out of control to stop eating.)

Do you purge (make yourself vomit after a meal)? ☐ Yes, how often _____/day ☐ No

Approximate age when you first seriously dieted?_____________________

Weight Loss Programs/Diets/Medications:

(Please list type and dates.)

Diet Program	Year and Duration	Total Weight Loss	Documentation Available? Yes or No
Atkins/Zone			
Dietitian			
HCG (Releana)			
Jenny Craig			
Metabolife			
Nutri System			
Opti/Medi Fast			
Phentermine/Fen-Fen			
Physician Supervised			
Weight Watchers			
Other:			

Have you been on any kind of steroids in the last 12 months?____

Exercise History:

Are you currently participating in a regular exercise program? ☐ Yes ☐ No

Do you have physical limitations that make increasing activity level difficult? ☐ Yes ☐ No

If yes, please explain:____

Do you have concerns regarding exercise and increase in physical activity? ☐ Yes ☐ No

If yes, please explain:____

Exercise History for the Past 12 Months:

Type of Program (Walk/Run/Jog/Swim/Dance/Bike/ Yoga/Strength Training/Etc.)	Start Date	End Date	Frequency and Duration per Week

How far can you walk without having difficulty? ☐ < 1 Block ☐ < ½ Mile ☐ < 1 Mile ☐ > 1 Mile

When you go past this distance, what limits your ability to continue?____

How many stairs can you climb without difficulty?____

Additional Health Information:

Please check if you have any of the following medical conditions:

- ☐ Acid Reflux
- ☐ Alcoholism
- ☐ Allergies
- ☐ Angioplasty w/Stent
- ☐ Anxiety
- ☐ Bladder Infections
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Bowel Incontinence
- ☐ Breathing Problems/Shortness of Breath
- ☐ Bulimia/Excessive Vomiting
- ☐ Cardiac Surgery
- ☐ Colitis
- ☐ Constipation
- ☐ COPD
- ☐ Currently on Blood Thinners
- ☐ Depression
- ☐ Diverticulitis
- ☐ DVT
- ☐ Easy Bruising
- ☐ Frequent Nausea
- ☐ Gallbladder Disease
- ☐ Gout
- ☐ Heart Failure
- ☐ Heart Bypass or Stents
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Leg Cramping
- ☐ Liver Disease
- ☐ Lung Disease/Pneumonia
- ☐ Migraine/Severe Headaches
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Oxygen Dependent
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rash/Dermatitis
- ☐ Sleep Apnea
- ☐ Steroid Use for Chronic Condition
- ☐ Urine Leakage
- ☐ Venous Stasis

Functional Health Status: ☐ Independent ☐ Partially Dependent ☐ Totally Dependent

Is your mobility limited? ☐ Yes ☐ All of the time ☐ Some of the time ☐ No

Have you fallen in the last year? ☐ Yes, explain________________________ ☐ No

Were you injured? ☐ Yes, explain ___________________________________ ☐ No

Women Only:

Date of last menstrual period:____________________________________Are your menstrual periods regular?_____________________

Are you using birth control? ☐ Yes, name: ___________________________ ☐ No

Number of Pregnancies:____Number of Live Births:________________________________

Are you experiencing menopausal symptoms? ☐ Yes ☐ No

Have you completed menopause? ☐ Yes ☐ No

Are you on Hormone Replacement Therapy? ☐ Yes ☐ No

Review of Systems

Please circle the appropriate response and answer all questions completely.

Constitutional Symptoms

Yes No Fever Yes No Chills

Yes No Headache Yes No Other

Eyes

Yes No Blurred Vision Yes No Pain

Yes No Double Vision Yes No Other

Ear/Nose/Throat/Mouth

Yes No Ear Infection Yes No Sore Throat

Yes No Sinus Problems Yes No Other

Respiratory

Yes No Wheezing Yes No Frequent Cough

Yes No Other Yes No Shortness of Breath

Gastrointestinal

Yes No Abdominal Pain Yes No Nausea/Vomiting

Yes No Indigestion Yes No Stomach or duodenal ulcer

Yes No Heartburn Yes No Other

Genitourinary

Yes No Urine Retention Yes No Painful Urination

Yes No Urinary Frequency Yes No Problems leaking urine

Yes No Other Yes No Problems with menstruating

Musculoskeletal

Yes No Joint Pain Yes No Neck Pain

Yes No Back Pain Yes No Other

Integumentary

Yes No Skin Rash Yes No Persistent itching

Yes No Boils Yes No Other

Neurological

Yes No Tremors Yes No Dizzy Spells

Yes No Other Yes No Numbness / Tingling

Yes No Other

Endocrine

Yes No Excessive Thirst Yes No Do you have Diabetes?

Yes No Tired / Sluggish Yes No Too Hot / Too Cold

Yes No Other

Cardiovascular

Yes No Chest Pains Yes No High Blood Pressure

Yes No Varicose Veins Yes No Swelling in Legs

Yes No Ulcer or non-healing sores on your legs?

Yes No Ever seen a Cardiologist?

Yes No Had a heart attack or any other heart problems?

Yes No Other

Hematologic/Lymphatic

Yes No Swollen Glands Yes No Blood Clotting Problem

Yes No Other

Allergic/Immunologic

Yes No Hay Fever Yes No Drug Allergies

Yes No Other

Psychological

Yes No Are you generally satisfied with your life?

Yes No Do you feel severely depressed?

Yes No Have you considered suicide?

Yes No Other

Other Questions

Yes No Have you been diagnosed with: HIV AIDS Hepatitis B Hepatitis C

Yes No Do you snore?

Yes No Have you ever been told that you stop breathing when you sleep?

Yes No Have you ever fallen asleep at the wheel?

Yes No Do you have to take a nap every day?

Yes No Do you feel rested when you make up in the morning?

Yes No Do you wake up (from a deep sleep) choking or coughing?

Yes No Have you ever been told you have sleep apnea? Do you use c-pap or bi-pap?

Yes No Have you ever had surgery for weight loss?

FINANCIAL AND PRIVACY POLICIES
Advanced Surgical Care of Northern Illinois, Ltd

Thank you for choosing us as your healthcare provider. We are committed to your medical treatment and well-being and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. We are also committed to protecting your personal health information as detailed in our policy "Medical Information Rights and Responsibilities".

Your Insurance Coverage

Advanced Surgical Care of Northern Illinois participates with many insurance company plans. We will file all charges incurred to your insurance company as a courtesy if we have accurate and complete insurance information; however, it is your responsibility to follow up on all claims with your insurance company to ensure payment. The entire balance due is your responsibility if we have not received payment from your insurance company within 45 days from the date of service. If your insurance company denies payment for any reason, you will be financially responsible for the entire balance. Please note that your health insurance policy is an agreement between yourself and your insurance company and it is your responsibility to understand and be familiar with the terms of that agreement, including, but not limited to any co-pays, deductibles or co-insurance amounts that are your responsibility. Our staff will be happy to assist you in obtaining the specific terms of your health insurance policy upon request.

Co-payments are due at the time service unless other arrangements have been made in advance. This includes applicable coinsurance and copayments. We accept cash, personal checks, VISA, and MasterCard. There is a service charge of $50.00 for returned checks.

For all services rendered to minor patients, we will look to the adult accompanying the patient, authorizing treatment and the parent or guardian with custody for payment.

Missed Appointments/Late Cancellations

Your appointment time is reserved especially for you. Please call to cancel your appointment at least 24 hours prior to your scheduled appointment if you will be unable to keep your appointment. This allows the practice to offer that time to another patient. If you fail to show up for your appointment or do not cancel 24 hours prior to your scheduled appointment, there may be a $50.00 fee charged to your account. Patients who repeatedly schedule and fail to keep their appointments or have late cancellations may be discharged from the practice.

Your Medical Information: Your rights - Our responsibilities

Your privacy is important to us. Please inform the staff if you need another copy or did not receive our privacy policy.

I have read and understand Advanced Surgical Care of Northern Illinois' Financial and Privacy policies. I agree to assign insurance benefits to Advanced Surgical Care and agree to release any medical or other information necessary to process insurance claims.

Please Print the Name of the Patient: ______________________________

Signature of Patient or Responsible Party if a minor: ___________________________

Date: __________________________

Consent for Release of Health Information

Patient name: _______________________________________

DOB: _________________________

Please list your preferred Numbers:	Type (please circle one)	Leave Detailed Message (please circle one)	Leave Detailed Lab/Test Results (please circle one)
Primary Phone #	Home Work Cell	Yes No	Yes No
Secondary Phone #	Home Work Cell	Yes No	Yes No

*Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV, Drug/Alcohol treatment and or Genetic testing.

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Advanced Surgical Care locations and Physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Name	Relationship	Release SHI?
		Yes No
		Yes No
		Yes No
		Yes No

Signature: ____ Date: _________________________

Printed name if **Responsible Party of Minor** or **Power of Attorney**: ____

Relationship to patient: _____________________________________