Bariatric Registration Paperwork

Patient Information

First Name: _____ M.I.:_____ Last Name: _____

Birth Date: ____/____/_____ Sex: ☐ M ☐ F Social Security Number: _____- _____-_____

Height: _____ Weight: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Ethnicity: ☐ American ☐ Indian ☐ Alaskan Native ☐ Asian ☐ Caucasian ☐ Black or African ☐ Pacific Islander ☐ Other ☐ Prefer not to answer

Employer: _____ Phone (____) ____-_____

Primary Insurance (Please provide all requested information)

Insurance Company: _____ Benefits Phone Number: (____) _____-_____

Plan Type: ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Other: _____

Group #: _____ Member #:_____

Whose insurance is this? ☐ Self – Skip to secondary insurance ☐ Other – Complete this section

Relationship to patient: ☐ Spouse ☐ Parent ☐ Other: _____ Social Security #:____-____-_____

First Name: _____ M.I.:_____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Employer: _____ Phone (____) ____-_____

Secondary Insurance (Please provide all requested information)

Insurance Company: _____ Benefits Phone Number: (____) _____-_____

Plan Type: ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Other: _____

Group #: _____ Member #:_____

Whose insurance is this? ☐ Self – Skip to secondary insurance ☐ Other – Complete this section

Relationship to patient: ☐ Spouse ☐ Parent ☐ Other: _____ Social Security #:____-____-_____

First Name: _____ M.I.:_____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Employer: _____ Phone (____) ____-_____

Emergency Contact

Name: _____

Relationship to Patient: _____ Phone: (_____) _____ - _____

Please tell us how you heard about us?

☐ Family/Friend ☐ Seminar – Peachtree Bariatric ☐ Seminar – Online ☐ Newspaper ☐ Physician
☐ Radio ☐ Employee Referral ☐ Trade Show/Expo/Health Fair ☐ Web/Online ☐ Other:

I understand and acknowledge that in some circumstances Peachtree Surgical may file a claim with my health insurance as a courtesy to me and that I will be responsible for all billable services not covered by insurance. I am responsible for paying my co-pays at the time of service.

If I do not have benefits, I will be required to pay cash. If benefits are not determined, I understand that I may pay cash. In this case we will not file a health insurance claim for me, but may provide me with information to file the claim myself.

I have provided you with complete, current, and accurate information about all insurance coverage. Should any information regarding my insurance change, I agree to give notification immediately.

I agree to assign my health insurance benefits to Peachtree Surgical for the services rendered at this facility.

Name of patient or guardian: _____

Signed by: _____ Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Health History and Review of Systems (Please check all that apply)

Constitutional

Fatigue / Tiredness	
Fever	
Skin	
Wounds that are slow to heal	
Skin Cancer	
Chronic rash	
Psoriasis / Eczema	

Respiratory

Asthma – Yr diagnosed ____	
Shortness of breath at rest / activity	
Flights of stairs you can climb ____	
COPD / Emphysema	
Snoring	
Difficulty sleeping flat	
Awakening at night	
Morning headaches	
Daytime drowsiness	
Observed apnea episodes	
Chronic insomnia	
Sleep Apnea – Yr diagnosed _____ ☐ CPAP ☐ BiPAP	

Cardiovascular

Chest pain at rest / activity	
Heart attack (MI) – Yr diagnosed ___	
Irregular heart beat – Yr diagnosed __	
Heart Disease – Yr diagnosed ____	
Congestive Heart Failure – Yr diagnosed ___	
High Blood Pressure (HTN) – Yr diagnosed ___	
Pregnancy Induced HTN	
Pacemaker / Defibrillator	
History of heart surgery	
High cholesterol / Triglycerides – Yr diagnosed___	
Deep vein thrombosis (blood clot)	
Painful varicose veins	
History of Rheumatic Fever	

Other

_____

_____

_____

_____

_____

_____

_____

_____

Gastrointestinal

Heartburn / Reflux – Yr. diagnosed ___	
Difficulty swallowing	
Painful swallowing	
Hoarseness	
Peptic Ulcer Disease	
Frequent nausea	
Frequent vomiting	
Chronic abdominal pain	
Chronic diarrhea	
Chronic constipation	
Blood in stool	
Painful Bowel Movements	
Change in stool size	
Irritable Bowel Syndrome	
Crohn's Disease	
Ulcerative Colitis	
Cirrhosis	
Fatty liver	
Elevated liver enzymes	
Hepatitis ☐ A ☐ B ☐ C ☐ Not sure	
Hernia – Yr diagnosed _____ ☐ Hiatal ☐ Inguinal ☐ Umbilical ☐ Ventral ☐ Not sure	

Musculoskeletal

Swelling of legs /feet	
Osteo-Arthritis	
Rheumatoid Arthritis	
Lupus	
Scleroderma	
Joint pain ☐ Limits ability to walk or exercise ☐ Ankles ☐ Knees ☐ Feet ☐ Hips ☐ Back	
Herniated Disc	

Hematologic/Lymphatic

Anemia, Type_____	
Blood clotting problem	
Sickle Cell Disease	
Blood transfusion – Year _____	
HIV – Yr diagnosed _____	

Endocrine

Hyperthyroidism (High)	
Hypothyroidism (Low)	
Goiter	
Diabetes – Yr diagnosed _____ ☐ Type 1 ☐ Type 2 ☐ Gestational	
Chronic steroid use	
Cushing's Disease	

Neurological

Seizures	
Light headedness	
Numbness	
Tremors	
Loss of consciousness	
Narcolepsy	
Stroke	
Migraine	
Fibromyalgia	
Multiple Sclerosis	

Psychological

Depression	
Anxiety Disorder	
Suicidal thoughts	
Suicide attempts	
Bi-Polar Disease	
Obsessive Compulsive Disorder	
Schizophrenia	
Anorexia	
Bulimia	
Binge eating	

Genitourinary

Frequent urination	
Urine leakage when coughing or laughing	
Kidney Disease	
Kidney Stones	
Blood in urine	
Painful urination	

Men's Health

Loss of erection	
Last Prostate exam (date)_____	
Prostate Cancer	
Enlarged breast tissue	

Women's Health

Polycystic Ovarian Syndrome	
Menopause	
Irregular periods	
Heavy periods	
Infertility	
Facial hair growth	
Breast Cancer	
Last Menstrual period (date)	

Provider's Signature: _____ **Date:** _____ / _____ / _____

Patient Name: _____ Date of Birth: _____/_____/_____

Weight Loss History

How many years have you been overweight? _____ Have you had weight loss surgery? ☐ Yes (describe below) ☐ No

Weight Loss Surgery Type	Date	Surgeon	Weight Loss / Gain
			☐ Loss _____ lbs ☐ Gain _____ lbs
			☐ Loss _____ lbs ☐ Gain _____ lbs

Diet Programs and Supplements (Please indicate which of the following diets or plans you have attempted.)

Program	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
Atkins Diet		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Grapefruit Diet		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Herbalife		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Jenny Craig		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
LA Weight Loss		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Liquid Diets		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Low Carbohydrate		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Medifast		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Metabolife		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Nutri-System		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Optifast		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Protein		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Slim Fast		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
South Beach		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
TOPS		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Weight Watchers		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Other _____		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs

Weight Loss Medication History (Please indicate which of the following diets or plans you have attempted.)

Medication	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
Amphetamines		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Phentermine (Adipex, Fastin, Pondimen)		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Phen-Fen		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Redux (Dexafenaflouramine)		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Xenical (Orlistat)		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Meridia (Sibutramine)		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Other _____		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs

Non-Dietary Therapies (Please indicate which of the following diets or plans you have attempted.)

Therapy	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
Regular Exercise		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Hypnosis		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Behavior Modification		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Acupuncture		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs
Other _____		☐ Yes ☐ No	☐ Loss _____ lbs ☐ Gain _____ lbs

Provider's Signature: _____ **Date:** _____ / _____ / _____

Patient Name: _____ Date of Birth: _____/_____/_____

Family / Social / Surgical History

Surgical History (Please list all minor and/or major surgical procedures and operations excluding weight loss surgery.)

Procedure	Date	Reasons

Family History (Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Sibling 1	Sibling 2	Sibling 3
Is this person living?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Age at death									
Cause of death									
Obesity									
Cancer									
Diabetes									
Hypertension									
Heart Attack									
Heart Disease									
High Cholesterol									
Malignant Hyperthermia									
Stroke									
Unknown History									

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner Number of Children: _____

Spouse / Partner Name: _____ Phone Number: (_____) _____-_____

Patient's Occupation: _____

Smoking	Dipping	Alcohol	Illicit / Illegal Drug Abuse
☐ Current ☐ Past	☐ Current ☐ Past	☐ Current ☐ Past	☐ Current ☐ Past
Packs per day _____	Dips per day _____	Drinks per day _____	Substance _____
# of years _____	# of years _____	# of years _____	# of years _____
Last used _____	Last used _____	Last used _____	Last used _____

Provider's Signature: _____ **Date:** _____ / _____ / _____

Patient Name: _____ Date of Birth: _____/_____/_____

Current Medications

Medications, Vitamins, and Supplements

Please list all medications (over the counter and prescribed), vitamins and supplements you are currently taking.

Name of Medication	Dosage	Frequency	Start Date	Reason		Notes (for provider use only)

Name of Vitamin / Supplement	Dosage	Frequency	Start Date	Reason		Notes (for provider use only)

Primary Care Physician: _____ Phone: (_____) _____ -_____ Fax: (_____) _____-_____

Ob /Gyn: _____ Phone: (_____) _____ -_____ Fax: (_____) _____-_____

Allergies:

Do you have any allergies? ☐ No ☐ Yes Please describe _____

Allergic to any medications? ☐ No ☐ Yes Please list _____

Allergic to Latex? ☐ No ☐ Yes Please describe reaction _____

Have you or any of your family members had an adverse reaction to anesthesia? ☐ Yes ☐ No

Provider Use Only **(Do Not Write Below This Line)** **Information Reviewed By:**

Provider Signature	Date	Provider Signature	Date	Provider Signature	Date
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___	_____	___/___/___

Patient Name: _____ Date of Birth: _____/_____/_____

Eating / Exercise Behaviors
Initial Visit

Are you currently on a diet? ☐ No ☐ Yes – Which One? _____

Which of the following diets have you tried? ☐None ☐ Dexatrim ☐ Acupuncture ☐Hypnosis ☐ Jaw Wiring ☐ Amphetamines ☐ Herbal Life ☐Other _____

Eating Behaviors: # of Meals / day: _____ # of Snacks / day: _____

Type of Liquids: _____# of oz. / day: _____

Describe Your Typical Menu:

Morning: _____

_____

Midday: _____

_____

Evening: _____

_____

Night: _____

_____

How often do you eat out? ☐ 1-5 meals /week ☐ 6-10 meals /week ☐ 10+ meals /week

Typically are you experiencing any of the following? (Check all that Apply)

☐ Late Night Snacking ☐ Constantly Snacking ☐ Eating Quickly

☐ Frequently Eating Fast Food ☐ Large Bites ☐ Large Portions

Please describe you racial background: ☐ African American ☐ American Indian ☐ Asian ☐ Pacific Islander

☐ White (Hispanic) ☐ White (non-Hispanic) ☐ Other _____

Exercise: Are You Currently Exercising?

☐ Yes What Do You Do for Exercise?

☐ Walking / Jogging ☐ Pilates / Yoga ☐ Strength Training ☐ Swimming ☐ Tennis ☐ Biking

☐ Aerobics / Elliptical ☐ Other _____ How often? _____ Duration? _____

☐ No What Keeps You from Exercising? ☐ Joint Pain ☐ Fatigue ☐ Lack of Time ☐ No Motivation

☐ Other: _____

Quality Of Life Survey

1. **In general would you say your health is?** ☐**Exellent** ☐**Very Good** ☐ **Fair** ☐ **Poor**

2. **Compared to one year ago, how would you rate your health in general now?**
   ☐**Much better than 1 year ago**
   ☐**Somewhat better than a year ago**
   ☐**About the same**
   ☐**Somewhat worse than 1 year ago**
   ☐**Much worse than 1 year ago**

Please check the following answer: 1-Yes, limited a lot, 2-Yes, Limited a little, 3-No, not limited at all

QUESTIONS	1	2	3
3.The following questions are about activities you might do during a typical day. Does your health now limit you in vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?			
4. Does your health now limit you in moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?			
5. Does your health now limit you with the following? A. In lifting or carrying groceries?			
B. In climbing several flights of stairs?			
C. In climbing one flight of stairs?			
D. In bending, kneeling, or stooping?			
E. In walking more than a mile?			
F. In walking several hundred yards?			
G. In walking hundred yards?			
H. In bathing or dressing yourself?			

Please check the following answer: 1. All of the time. 2. Most of the time. 3. Some of the time. 4. A little of the time. 5.None of the time.

QUESTIONS	1	2	3	4	5
6. During the past few weeks, as a result of your physical health, how much of the time have you had to cut down on the amount of time you spent on work or other activities?					
7. During the last 4 weeks, as a result of your physical health, how much of the time have you accomplished less than you would like?					
8. During the last 4 weeks, as a result of your physical health, how much of the time were you limited in the kind of work or other activities you could do?					
9. During the last 4 weeks, as a results of your physical health how much of the time have you had difficulty performing work?					

Please check the following: 1.Definately True 2. Mostly True 3.Don't Know 4. Definitely False

10. How TRUE or FALSE is each of the following statements for you? I seem to get sick a little easier than other people.			
11. I am as healthy as anybody I know.			
12. I expect my health to get worse.			
13. My health is excellent.			