

## PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION:** (Please use full legal name, no nicknames)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

*Please tell us how you heard about us:* \_\_\_\_\_ *Referred by:* \_\_\_\_\_

**GUARANTOR INFORMATION:** (List person or insured name responsible for bill – use full legal name, no nickname)

Relationship of Guarantor to Patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM  
INSURANCE INFORMATION**

(Please allow receptionist to photocopy your insurance ID cards)

*\*\*If someone other than patient is the insured party, please include Date of Birth for claims\*\**

**PRIMARY INSURANCE:**

Plan Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
\_\_\_\_\_

Claims Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY INSURANCE:**

Plan Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
\_\_\_\_\_

Claims Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

## PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Medical Edge is unable to collect from my insurance carrier for whatever reason.

**MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have received and read a copy of the MedicalEdge healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO MAIL, CALL, OR EMAIL:**

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREAT:**

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(If different from patient)

GUARANTOR NAME (Please Print): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM  
FINANCIAL RESPONSIBILITY AGREEMENT**

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

**Signature:** \_\_\_\_\_  
(Please sign here- Patient or Responsible Party)

**Date:** \_\_\_\_\_

**Responsible  
Party Name:** \_\_\_\_\_  
(Please print name of Patient or Responsible Party)

Patient Name: _____	Date of birth: _____
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**PATIENT REGISTRATION FORM  
ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRATICES**

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

\_\_\_\_\_  
Name of Patient (Print)

Signature of Patient	Date of Signature
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\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient

**Request for Confidential Communication of Your Protected Health Information**

Please circle your response to the following:

- |  |     |    |     |
|--|-----|----|-----|
| May we leave messages concerning your <b>appointments</b> with a co-worker, receptionist or secretary that regularly answers your calls? | Yes | No | N/A |
| May we leave <b>messages</b> on a voice mail at work?  | Yes | No | N/A |
| May we discuss your <b>appointments/treatment</b> with your spouse?  | Yes | No | N/A |
| If you are over the age of 18, still living at home, may we discuss your <b>appointments/treatment</b> with your parent(s) or guardian?  | Yes | No | N/A |
| If you are over the age of 18, may we discuss your <b>appointments/treatment</b> with your children?                                     | Yes | No | N/A |

You must inform us in writing if you wish to change the manner in which this office communicates to you.

Thank You.

(Please place in the patient's medical record)

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM  
AUTHORIZATION AND RELEASE**

In connection with arranging bariatric surgery, TLCEdge may require information from each patient's medical records.

I hereby grant TLCEdge permission to obtain such information from my medical records as they may require arranging the bariatric surgery. In this regard and this regard only, authorized agents of TLCEdge shall have the right to sign, as my representative, any information disclosure authorization required by the health care provider or other person maintaining my medical records, including authorizations required in order to comply with the privacy rules of the Health Insurance Portability & Accountability Act of 1996.

TLCEdge is further authorized to disclose such information to the health care provider performing the bariatric surgery. In granting such authorization, I also release any and all claims, actions and demands against TLCEdge, its officers, directors, employees and agents that might arise as a result of any such disclosure.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date of Signature

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

## PATIENT REGISTRATION FORM BARIATRIC MEDICAL HISTORY AND INFORMATION

Please answer the following questions:

What is your reason for this visit? \_\_\_\_\_

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Females only: Last Menstrual Period: \_\_\_\_\_

Type of Contraception: \_\_\_\_\_

Do you plan to become pregnant in the next 18 months?  Yes  No

FAMILY HISTORY		SOCIAL HISTORY	
Family Member with this condition?		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Asthma		<input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Bleeding Disorder		Number of children:	
Cancer		Number of children still living at home:	
Cholesterol		Occupation:	
Depression		Work Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Diabetes		<input type="checkbox"/> Disabled	
Early Death		Caffeine Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease		If yes, amount and type	
Hypertension		Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney Disease		If yes, # of drinks/week:	
Obesity		Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures		If yes, # packs/day # years smoking	
Stroke		If quit, year quit	
Thyroid Disease		Exercise: Frequency Duration	
Other:		Type	

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM  
BARIATRIC MEDICAL HISTORY AND INFORMATION**

<b>Medications you are taking:</b>					
Name of Medication	Dosage?	Frequency?	How long on this medication?	Reason for taking?	How often missed?

<b>Surgical History</b>			
Procedure	Date	Location	Indication

Please list all other medical conditions, illness or important information not mentioned previously

\_\_\_\_\_

\_\_\_\_\_

What concerns you most about your health?

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### PATIENT REGISTRATION FORM--BARIATRIC MEDICAL HISTORY AND INFORMATION

Past Medical History									
Condition	Y	N	Year	Comments	Condition	Y	N	Year	Comments
Abdominal wall hernia					Heart Murmur				
Angina					Hepatitis				
Anemia/Type?					Herniated Disk				
Anorexia					Hiatal Hernia				
Anxiety					High Blood Pressure				
Asthma					HIV/AIDS				
Bulimia					Hyperthyroidism				
Panic Disorder					Hypothyroidism				
Blood transfusion/ tattoo					Kidney Disease				
Chronic Obstructive Pulmonary Disease (COPD)					Kidney Stones				
Cirrhosis					Migraines				
Colitis/ Irritable Bowel / Crohn's Disease					Multiple Sclerosis (MS)				
Congestive Heart Failure					Neuropathy				
Coronary Bypass Surgery					Obstructive Sleep Apnea				
Deep Venous Thrombosis (blood clots in legs)					Use CPAP or BiPAP machine?				
Depression					Osteoarthritis				
Diabetes – Type 1					Osteoporosis				
Diabetes – Type 2					Arrhythmia (abnormal heartbeat)				
Gestational Diabetes					Peptic Ulcer Disease / Bleeding Ulcers				
Pre-Diabetes					Peripheral Arterial Disease				
Elevated Cholesterol					Pulmonary Embolism				
Elevated Triglycerides					Rheumatoid Arthritis				
Emphysema					Seizure Disorder				
Esophagitis					Systemic Lupus				
Reflux Disease (GERD)					Other Autoimmune Disorders				
Heart Attack (MI)					Urinary Incontinence				
Heart Disease					Leaking when cough or sneeze				
Other:					Leaking with straining				

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM--BARIATRIC MEDICAL HISTORY AND INFORMATION**

Weight history: Weight one year ago: \_\_\_\_\_

How old were you when weight became an issue? \_\_\_\_\_

**Weight Loss Medication History**

Medication	Dates	Dosage	Physician supervised	Amount of weight loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux				
Xenical (Orlistat, Alli)				
Meridia (Sibutramine)				
Other diet medication:				

**Diets you have tried:**

Program	Year	Duration	Physician supervised	Amount of weight loss
Atkins				
Herbalife				
Jenny Craig				
LA Weight Loss				
Liquid diets				
Low Calorie diet				
Medifast				
Metabolife				
Nutri-Systems				
Optifast				
Slim Fast				
Weight Watchers				
LA Weight Loss				
Regular Exercise				
Hypnosis				
Acupuncture				
Behavior Modification				
Other:				

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**PATIENT REGISTRATION FORM  
BARIATRIC MEDICAL HISTORY AND INFORMATION**

What is your weight goal? \_\_\_\_\_

When do you think you can achieve this goal? \_\_\_\_\_

What obstacles do you see in the path of this achievement? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you!