

PATIENT REGISTRATION FORMS

**Today's Date: _____ Clinic Name _____

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

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

Work Phone #: (_____) _____ - _____

E-mail Address: _____ Cell Phone #: (_____) _____ - _____

Emergency Contact Name _____ Emerg 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 nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

*Last Name: _____ *First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address: _____

Work Phone #: (_____) _____

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 #: _____ Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name: _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

***REQUIRED FILEDS – PLEASE COMPLETE FOR BILLING**

***ATTACH COPY OF INSURANCE CARDS**

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____

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 MedicalEdge 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 E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail 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 TREATMENT:

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): _____

PAST MEDICAL HISTORY:

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

SURGICAL HISTORY:

| Procedure | Date | Location | Indication |
|-----------|------|----------|------------|
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Please List All Other Medical Conditions, Illnesses, or Important Information Not Mentioned Previously

What most concerns you about your health? _____

What would you like to work on most? _____

SYSTEM REVIEW: (Please CIRCLE all that apply)

Do you have any of the following problems or symptoms NOW or on a recurring basis?

Constitutional:

Fatigue
Fever/Chills
Night Sweats

Skin:

Bruising Easily
Hives

Itching
Nail Changes
Chronic Rashes
Ulcers

Head/Eyes/Ears/Nose/Throat

Blurred Vision
Headaches
Double Vision
Vision Loss
Vertigo/Spinning Sensation
Bleeding Gums/ Mouth Ulcers
Voice Changes/ Hoarseness

Neck and Lymph:

Neck Masses/Swelling
Neck Pain/Stiffness
Persistent Swollen Glands
Hard Lymph Nodes

Respiratory:

Chronic Cough/Freq Cough
Decreased Exercise Tolerance
Snoring
Difficulty Breathing
Wheezing
Episodes of Apnea

Comments

Cardiovascular:

Fainting/Black Outs
Chest Pains/ Calf Pains
Pain in Neck/Arm/Jaw
Leg Pain with Activity
Shortness of Breath
 with activity
Edema/Swelling in
extremities
Irregular Heartbeat
Elevated Blood Pressure
Difficulty Breathing
 Lying Flat
Palpitations
Rapid Heart Rate
Waking Short of Breath
Coldness or color change
 in legs or feet
Loss of Pulses

Gastrointestinal:

Chronic Diarrhea
Excess Gas
Stomach/Abdominal Pain
Black/Tarry Stools
Blood in Stools
Change in Bowel Habits
Food Intolerance
Vomiting Blood
Heartburn/ Indigestion
Jaundice/Yellow Skin
Nausea
Frequent Vomiting
Difficulty Swallowing

Psychiatric

Anxiety
Hallucinations
Depression
Mood Changes

Comments

Hematology:

Excessive Bleeding
Anemia
Blood Clots
Nose Bleeds

Genitourinary:

Blood in Urine

Difficulty Urinating
Nighttime Urination
Impotence
Heavy Periods

Endocrine:

Excessive Thirst
Appetite Changes
Cold Intolerance
Excessive Urination
Sexual Dysfunction

Musculoskeletal:

Back Pain
Decreased Joint
 movement
Joint Pain
Muscle Weakness
Loss of Muscle

Neurological:

Dizziness/ Fainting
Headaches
Incoordination
Near Fainting Spells
Blackouts
Loss of Power in
 Arms/Legs
Tremors

Name _____ Date _____

Date of Birth _____

| | |
|------------------------|------------------|
| Office Use: ID # _____ | Sharepoint _____ |
|------------------------|------------------|

| | | | |
|--------------------|-------------|------------------------------|------------------|
| Office Use: | | Time: Start _____ Stop _____ | |
| BP _____ / _____ | Pulse _____ | | |
| Ht _____ | Wt _____ | BMI _____ | % Body Fat _____ |
| | | Waist _____ | |

| | | |
|------------------------|---|--------------------|
| Weight History: | Weight: 1 year ago _____ | 10 years ago _____ |
| | Highest Adult Weight _____ | |
| | How old were you when weight became an issue? _____ | |

Weight Loss Medication History

| <i>Medications</i> | <i>Dates</i> | <i>Dosage</i> | <i>MD Supervised</i> | <i>Weight Loss</i> |
|----------------------------|--------------|---------------|----------------------|--------------------|
| Amphetamines | | | | |
| Phentermine | | | | |
| (Adipex, Fastin, Pondimin) | | | | |
| Phen-Fen | | | | |
| Redux | | | | |
| (Dexafenflouramine) | | | | |
| Xenical (Orlistat, Alli) | | | | |
| Meridia (Sibutramine) | | | | |
| Other Diet Medication | | | | |
| | | | | |

Name _____

Date of Birth _____

Allergies to medications / vaccines: _____

Allergies or intolerances to foods: _____

Allergies to environmental or contact allergies (ex: poison ivy): _____

Dieting History (please indicate which of the following diets or plans you have attempted)

| <i>Program</i> | <i>When</i> | <i>Duration</i> | <i>MD Supervised</i> | <i>Weight Loss</i> |
|-----------------|-------------|-----------------|----------------------|--------------------|
| Atkins | | | | |
| Grapefruit Diet | | | | |
| Herbalife | | | | |
| Jenny Craig | | | | |
| Liquid Diets | | | | |
| Medifast | | | | |
| Metabolife | | | | |
| Nutri-System | | | | |
| Optifast | | | | |
| Pritikin Diet | | | | |
| Slim Fast | | | | |
| TOPS | | | | |
| Weight Watchers | | | | |
| LA Weight Loss | | | | |
| Other | | | | |
| | | | | |

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

| <i>Therapy</i> | <i>When</i> | <i>Duration</i> | <i>MD Supervised</i> | <i>Weight Loss</i> |
|-----------------------|-------------|-----------------|----------------------|--------------------|
| Regular Exercise | | | | |
| Hypnosis | | | | |
| Behavior Modification | | | | |
| Acupuncture | | | | |
| Other | | | | |
| | | | | |

Name _____

Date of Birth _____

Do you drink carbonated drinks?
Amount and frequency Yes No

Do you use caffeine?
Amount and frequency Yes No

Do you use alcohol?
Amount and frequency Yes No

Do you use tobacco?
Number of packs per day Yes No
Number of years smoking _____
If quit, year quit _____

Where do you consume your meals?
___ Home ___ Work-break room ___ Work-desk ___ Car ___ Restaurant ___ Fast Food ___ Vending
___ Other Who prepares the meals? _____

How long does it take to finish a meal? ___ 1-10 min ___ 11-15 min ___ 16-20 min ___ 21-30 min ___ >45

Does your work or lifestyle affect or inhibit your meal times?
___ All the time ___ Most of the time ___ Some of the time ___ None of the time

| |
|--|
| <p>Office Use Only</p> <p>IBW: _____ ABW: _____ KCAL: _____</p> |
|--|

Have you ever been diagnosed with an eating disorder (anorexia nervosa, bulimia, bingeing/purging through exercise or laxative use)?

When _____ Treatment _____

Comments on the above _____

Name _____

Date of Birth _____

Do you eat more when you are: (Circle what applies)

Stress Yes/No Boredom Yes/No Coping Yes/No Relaxation Yes/No
Grief Yes/No Celebration Yes/No Pressure from others Yes/No Tired Yes/No
Escape Yes/No Temptation Yes/No Watching TV/Computer Yes/No

How will you deal with these areas once you have surgery?

Do you have access to a therapist or counselor? Yes No
Have you had a psychological assessment for the surgery yet? When _____ Name _____

Goals:

Patient Expectations regarding Lap Band / Weight loss intervention

What do you expect from this? _____

What is your weight goal? _____

When do you think you can achieve that? _____

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

Do you have a good support system after surgery? *Please describe* _____

Additional comments you feel we should know: _____

Office Use Only
RD A&P _____