

# PATIENT REGISTRATION FORM

**\*\*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 FIELDS-PLEASE COMPLETE FOR BILLING.**

**\*ATTACH COPY OF INSURANCE CARDS.**

*Please read and sign back of form.*





## AUTHORIZATION AND RELEASE

In connection with arranging laparoscopic gastric band 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 laparoscopic adjustable gastric banding 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 laparoscopic adjustable gastric banding 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.

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Signature

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Printed Name

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Date

*TLCEdge and TLCEdge Surgical Weight Loss are Service Marks of Medical Edge Healthcare Group*

TLCEdge Surgical Weight Loss ☐ 888.244.2944 ☐ [www.tlcedgesurgicalweightloss.com](http://www.tlcedgesurgicalweightloss.com)

**BARIATRIC MEDICAL HISTORY AND INFORMATION**  
OFFICE USE ONLY

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

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: \_\_\_\_\_

<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

<b>Other Symptoms:</b>		
<b>Do you have any of the following problems or symptoms NOW or on a recurring basis?</b>		
<b>Respiratory:</b> Chronic cough/Freq cough Decreased exercise tolerance Snoring Difficulty breathing Wheezing Episodes of apnea <b>Endocrine:</b> Excessive thirst Appetite changes Cold intolerance Excessive urination Sexual dysfunction	<b>Cardiovascular:</b> 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 when lying flat Palpitations Waking short of breath Coldness or color change in legs/feet Loss of pulses	<b>Gastrointestinal:</b> Chronic diarrhea Excess gas Stomach/Abdominal pain Black or tarry stools Blood in stools Change in bowel habits Food intolerance Vomiting blood Heartburn or indigestion Jaundice / yellow skin Nausea Frequent vomiting Difficulty swallowing
<b>Musculoskeletal:</b> Back pain	Decreased joint movement Muscle weakness	Loss of muscle Joint pain

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: \_\_\_\_\_

<b>Past Medical History</b>									
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: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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, Pondimin)				
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: \_\_\_\_\_

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!