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.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ____ **Date of Birth:** ______________
First Name M.I. Last Name

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): ____

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.

____
Signature

____
Printed Name

____
Date

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

BARIATRIC MEDICAL HISTORY AND INFORMATION

TLC Edge

OFFICE USE ONLY

Patient Name: ____

Date of Birth _______________________ Date of Visit: _________________________

Ht: WT:	Waist:	BP: / Pulse:	BMI:
	LMP:		

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is your reason for this visit? ____

Allergies (especially to drugs)____

(Females Only) Last Menstrual Period: ___________ **Type of Contraception**___________________________

Do you plan to become pregnant in the next 18 months? Yes ____ No ____ Sterility Surgery?_______________

Medications you are taking:

Name of Medication	Dosage	Frequency	How Long on this Medication	Reason for Taking	How Often Missed?

FAMILY HISTORY:

	Family Member with this condition?
Asthma	
Bleeding Disorder	
Cancer	
Cholesterol	
Depression	
Diabetes	
Heart Disease	
Hypertension	
Kidney Disease	
Obesity	
Seizures	
Stroke	
Thyroid Disease	
Early Death	
Other	

SOCIAL HISTORY:

Marital Status: Single_____ Married____ Separated ____ Divorced ____ Widowed _____

Number of Children _________ **Number of children still living at home**: ___________

Occupation: ________________________________

Work Status: Full Time ____ Part Time ____ Disabled ____

Caffeine Use ____Yes ____ No ______Amount _______Type

Alcohol Use ____Yes ____ No # drinks/week __________

Type: ________________________________

Tobacco Use ____ Yes ____ No # of packs per day __________ # of years smoked _______If Quit, Year quit___________

Exercise: Frequency __________ Duration ______________

Type of Exercise ______________________

BARIATRIC MEDICAL HISTORY AND INFORMATION

TLC Edge

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:									

BARIATRIC MEDICAL HISTORY AND INFORMATION

TLC Edge

SURGICAL HISTORY:

Procedure	Date	Location	Indication

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? ____

____

____

____

TLC Edge

SYSTEM REVIEW: (Please CIRCLE all that apply)

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

Constitutional: **Comments**

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

Cardiovascular: **Comments**

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

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

TLC Edge

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

Medications	*Dates*	*Dosage*	*MD Supervised*	*Weight Loss*
Amphetamines				
Phentermine				
(Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux				
(Dexafenaflouramine)				
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)

Program	***When***	***Duration***	***MD Supervised***	***Weight Loss***
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)

Therapy	***When***	***Duration***	***MD Supervised***	***Weight Loss***
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				
Other				

Name___________________
Date of Birth_____________

Do you drink carbonated drinks? Yes No
Amount and frequency ___________________________

Do you use caffeine? Yes No
Amount and frequency ___________________________

Do you use alcohol? Yes No
Amount and frequency ___________________________

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

Where do you consume you 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

Office Use Only
IBW:__________ ABW:__________ KCAL:__________

Have you ever been diagnosed with an eating disorder (anorexia nervosa, bulimia, binging/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____