DEMOGRAPHIC INFORMATION

Patient Information:

*Name _____ *DOB _____ M / F

Other Name _____ Maiden Name _____

*Physical Address _____

*City _____ *State _____ *Zip _____

*Cell Phone _____ Other Phone _____

Email_____ Is it okay for us to email you? Y N

Marital Status _____ Patient's Social _____

Language _____ Race _____ Hispanic _____

Who can we speak with regarding your healthcare? _____

*In Case of Emergency _____ *Relationship to Patient_____

*Address_____ *City_____ *State_____ *Zip_____

*Best Contact Number _____ Other Number_____

*Person to Notify_____ *Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

*Best Contact Number _____ Other Number_____

Guarantor Information (Person responsible for payment of bill, if insurance does not cover)

*Name _____ *Relationship to Patient_____

*Address_____ *City_____ *State_____ *Zip_____

*Best Contact Phone Number_____ Other_____

Insurance Subscriber Detail: (who carries the insurance)

Subscriber_____ DOB_____ Sex_____ Race_____

Address_____ City_____ State_____ Zip_____

Phone_____ Social_____ Effective Date_____

Marital Status_____ Relationship to Patient_____

Employer_____ Employment Status_____

Employer Address_____ City_____ State_____ Zip_____

(*) Indicates a required field. Please look over your paperwork to insure it is filled out completely. If you are having any trouble, please do not hesitate to ask for help.

ADVANCED SURGERY & BARIATRICS OF NORTH TEXAS
1902 Hospital Blvd, Suite F
Gainesville, Texas 76240
Phone: 940-612-8710
Fax: 940-668-7965

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

_____ authorize _____
Patient Name (Printed) Name of Doctor/Facility to release information

_____ Fax Number _____
Patient Date of Birth

Phone Number _____

I, the undersigned, authorize the release of information specified below from the medical record(s) of the above named patient. Patient information is needed for continuing medical care. This authorization will remain in effect until revoked, in writing, by patient of other authorized individual.

INOFRMATION TO BE RELEASED:

____ History & Physical ____ Progress Notes, past 2 years ____ Lab/Pathology Reports
____ Radiology Reports ____ EKG's ____ Consult Report
____ Other: _____

Please release records to: ***Advanced Surgery & Bariatrics of North Texas- Dr. Leah Dill***
1902 Hospital Blvd, Suite F *Phone 940-612-8710*
Gainesville, TX 76240 *Fax 940-668-7965*

***** Please mail records of more than 25 pages*****

Name of person authorizing this disclosure (please print) _____

Signature _____ Date _____
Relationship to patient _____

ADVANCED SURGERY & BARIATRICS OF NORTH TEXAS
1902 Hospital Blvd Suite F
Gainesville, Texas 76240
940-612-8710 Phone
940-668-7965 Fax

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other offices under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designs as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended; I will be asked to read and sign additional consents forms prior to test(s) or procedure(s).

I certify that I have read and filly understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient/Representative	Relationship to Patient
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	Date

Advanced Surgery & Bariatrics of North Texas

1. *Cancellation/No Show Policy for Doctor Appointment*

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty-five dollar ($25) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3.*Cancellation/No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 10 days in advance you will be charged a seventy-five-dollar ($75) fee; this is will not be covered by your insurance company.

4. Account balances

We will require patients with self-pay balances do pay their account balances to zero (0) Prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____/____/___

Print Name /Patient Signature/ Patient/Guardian **Date**

Patient Account #_____ (Office Use Only)

ADVANCED SURGERY & BARIATRICS OF NORTH TEXAS

Medical Intake Questionnaire

Name:_____ Age _____ Height _____ Weight _____

Physician Information

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Pharmacy

Pharmacy Name: _____ Address:_____

Medications:

Medications	Dose/Frequency

Allergies:

Drugs/Foods	Reactions

Past Medical History:

Have you ever had any of the following? (Check all that apply)

Problems	Yes	No	Problems	Yes	No
High blood pressure			Hepatitis		
Diabetes			Stomach Ulcer		
Heart disease			Reflux/Heartburn		
Shortness of Breath			Cancer or Tumor		
Stroke			High Cholesterol		
Sleep Apnea			Thyroid Problems		
Asthma			Anemia (low blood count)		
Fatty Liver			Arthritis		
Blood clots or History of					
Other:					

Surgical History

Have you had previous Weight Loss Surgery? ❑Yes ❑ No

If yes, what type of surgery _____ What year? _____ Where _____

Please enter all other surgeries below

Type of Surgery	Date of Surgery

Family History

What illnesses have there been in your family?

Relation	List all major illnesses, or has the same problem as you do now	Living?	Age of Death
Father			
Mother			
Sibling			
Grandparents			
Child			

Social History

Tobacco: Do you currently smoke/use tobacco? ❑ Yes ❑ No

If yes, how many packs/can per day?_____ How many years? _____

Do you use alcohol? ❑ Never ❑ Rarely ❑ Occasionally ❑ Daily

Have you ever use illegal drugs? ❑ Yes ❑ No If yes, what kind? _____

Do you exercise? ❑ Yes ❑ No If yes, what type of exercise & how often? _____

Diet History

Example

When?	**2012**
What?	**Low Carb Diet**
How Long?	**8 months**
Weight Change?	**Lost 3 lbs**

When?	
What?	
How Long?	
Weight Change?	

When?	
What?	
How Long?	
Weight Change?	

When?	
What?	
How Long?	
Weight Change?	

Diagnostic Testing

Have you ever had:

Any heart test done? ❑ Yes ❑ No If yes, please describe _____

Patient Name_____

Do you have any of the following significant stomach or intestinal problems? If yes, please describe.

Stomach/Esophageal Ulcers or other disorders ❑ Yes ❑ No

Gastritis ❑ Yes ❑ No

Hiatal Hernia ❑ Yes ❑ No

GERD ❑ Yes ❑ No

Crohn's Disease ❑ Yes ❑ No

Irritable Bowel Syndrome ❑ Yes ❑ No

Chronic Diarrhea ❑ Yes ❑ No

Other stomach or intestinal issues:

_____

_____

Have you had an upper GI (barium swallow), upper endoscopy (EGD, scope), or colonoscopy? ❑ Yes ❑ No

If yes, please list year and results _____

STOP-BANG SLEEP APNEA QUESTIONNAIRE

STOP		
Do you SNORE loudly (louder than talking)?	YES	NO
Do you often feel TIRED, fatigued, or sleepy during the daytime?	YES	NO
Has anyone OBSERVED you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood pressure?	YES	NO
BANG		
BMI (Body Mass Index) more than 35kg/m2?	YES	NO
Age over 50 years old?	YES	NO
NECK Circumference greater than 16 inches (40CM)? (measurement will be taken with vitals)	YES	NO
GENDER: Male?	YES	NO
TOTAL YES'S		

High Risk of OSA: 5-8
Intermediate Risk of OSA: 3-4
Low Risk of OSA: 0-2

Patient Name _____ Date _____