Believe Bariatrics

Patient Information: (please print)

Name: ______________________ ______________________ - __________
Last First MI

Street Address: ______________________ ______________ ______ ________
Address Apt. # City State Zip

Home Phone #: ______________________ Cell #: ______________________

Email Address: ______________________ Preferred Method Contact: Home:___ Cell ___ Email ___

Sex: Male ___ Female ___ other_____ Birth Date:______________ Age: ________ SS # ______________

Employment Status: FT___ Part time___ Self Employed ___ Homemaker___ Student___ Disabled ___ Retired ___ Unemployed __

Employer: ______________________ Occupation: ______________________

Employer Address: ______________________ Work Phone: ______________

Marital Status: S ___ M ____ W ___ D_____ Engaged _____ How did you hear about us?______________

Spouse Name: ______________________ Birthdate: ______________ Phone: ______________

Emergency Contact Information:

Name: ______________________ Phone #______________

Address: ____

Relationship: Spouse____ Partner______ Friend _____ Parent ______ Other: ______________

I authorize that the above person can be contacted about my care. Yes _____ No _____

Pharmacy: ______________ Address: ______________________ City ________ Phone ___________

Referring Physician: ______________________ Phone ______________________

I authorize the use of this form for all insurance submissions and permit a copy to be used. I authorize the provider to act as my agent to obtain insurance payment. Co-payments, deductibles, and co-insurance will be collected according with the health insurance companies. Uninsured patients will be given a discounted cash price. Payment is due at the time of service. Appointments should be cancelled at least 4 hours in advance or fees will be assessed. New patient cancellations-$35 and established patients-$20. Return checks fee-$35 and miscellaneous paperwork completion such as FMLA, Disability-$25.

Health Insurance Non-Payment: Services that are partially paid by your insurance carrier or that have been deemed as the patient responsibility will be billed to you. Should you need special arrangements, please call the office.

By signing below, I certify that I have read the above information and it is correct. Any questions concerning the above information have been discussed. My signature also certifies my understanding and agreement with the above information.

Patient or Patient's Representative Signature:	
Date:	
Patient or Patient's Representative Printed Name:	
Relationship to Patient:	

Name:	DOB:

Current Medication:	Dosage:	Times per Day:	For:

Medication Allergy:	Reaction:

PATIENT HEALTH INFORMATION

Current Condition:	Comment:	Current Condition:	Comment:
☐ High Blood Pressure		☐ Arthritis	
☐ Heart Disease		☐ Joint Related Disease	
☐ High Cholesterol		☐ Heartburn	
☐ Previous Heart Attack		☐ Gastric Reflux (GERD)	
☐ Atrial Fibrillation		☐ Barrett's Esophagus	
☐ Blood Clots		☐ Hiatal Hernia	
☐ Asthma	Last Episode:	☐ Stomach Ulcers	When:
☐ Sleep Apnea	☐ C-Pap ☐ Bi-Pap	☐ Gallstones	
☐ COPD		☐ Kidney Stones	
☐ Emphysema		☐ Gout	
☐ Type I Diabetes	How Long:	☐ Colitis	
☐ Type II Diabetes	How Long:	☐ Pancreatitis	
☐ Hyperthyroid		☐ Cirrhosis	
☐ Hypothyroid		☐ Hepatitis	Type:
☐ Chronic Renal Failure		☐ Migraines	How Often:
☐ Crohn's Disease		☐ Seizures	Last One:
☐ Chronic Fatigue		☐ Anxiety	
☐ Fibromyalgia		☐ Depression	
☐ Multiple Sclerosis		☐ Bipolar	
☐ Extremity Swelling		☐ Suicidal Tendencies	☐ Thoughts ☐ Attempt(s)
☐ Anemia		☐ Anorexia	
☐ Cancer	Type:	☐ Bulimia	
☐ HIV		☐ Irregular Menses	
☐ Other Condition(s):		☐ Polycystic Ovaries	
☐ Other Condition(s):		☐ Anesthesia Issues	

Previous Surgeries:	Date:

Previous Weight Loss Surgery? ☐ No ☐ Yes Type: ______________ Date: ______________

Highest Weight: __________ Lowest Weight: __________

PATIENT SOCIAL HISTORY:

Do you smoke? ☐ **No** ☐ **Yes** ________ packs per ☐ day ☐ week ☐ **Quit** ________ ☐ months ☐ years ago Age Started:__________
Do you chew/dip tobacco? ☐ **No** ☐ **Yes** ________ packs per ☐ day ☐ week ☐ **Quit** ________ ☐ months ☐ years ago Age Started:__________
Do you drink alcohol? ☐ **No** ☐ **Yes** ________ drinks per ☐ day ☐ week ☐ month
Do you use recreational drugs? ☐ **No** ☐ **Yes** Type :______________ Frequency: ______________ ☐ **Quit** ________ ☐ months ☐ years ago

FAMILY HISTORY (CHECK ALL THAT APPLY):

Father's Status: ☐ Alive - Age: __________ ☐ Deceased at age: __________ If deceased, cause of death: ______________
Father's Medical History: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Paternal Grandfather: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Paternal Grandmother: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Mother's Status: ☐ Alive - Age: __________ ☐ Deceased at age: __________ If deceased, cause of death: ______________
Mother's Medical History: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Maternal Grandfather: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Maternal Grandmother: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Sibling's History: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Stroke
Females Only: # of Pregnancies: __________ # of Live Births __________
# of Still Births: __________ # of Miscarriages: __________ # of Terminations: __________

MEDICAL CONTACTS:

Primary Care Physician:	Phone Number:

OTHER TREATING PHYSICIANS:

Specialty:	Physician Name:	Phone Number:

I have provided accurate information to the best of my knowledge.

____

Patient or Patient Representative Signature Date

Preventative Questionnaire

Name: ______________________ D.O.B.: __________ Date: __________ ☐ M ☐ F

Household:

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Domestic Partner

Number of Children in Household: ______ Ages: ______ Other Occupants: ______________

Any Household History of Abuse? ☐ N ☐ Y - If Yes: ☐ Physical ☐ Mental ☐ Sexual

Resolved ☐ Y ☐ N - If No, would you like a referral for counseling? ☐ Y ☐ N

Any Household History of Addiction? ☐ N ☐ Y - If Yes: ☐ Alcohol ☐ Drugs ☐ Other: __________

Resolved ☐ Y ☐ N - If No, would you like a referral for counseling? ☐ Y ☐ N

Testing/Examinations:

Approximate month and year (mm/yy) of last:

EGD: ______________ ☐ Never

Colonoscopy: ______________ ☐ Never

Chest X-Ray: ______________ ☐ Never

EKG: ______________ ☐ Never

Stress Test: ______________ ☐ Never

Pap Smear: ______________ ☐ Never

Mammogram: ______________ ☐ Never

Bone Density: ______________ ☐ Never

Safety Practices:

Use Safety Belts? ☐ Y ☐ N

Text While Driving? ☐ Y ☐ N

Motorcycle Helmet? ☐ Y ☐ N ☐ N/A

Gun(s) in Home? ☐ Y ☐ N

If Yes, are they stored safely? ☐ Y ☐ N

STD Sexual Safety Practices (Condoms/Monogamy)? ☐ Y ☐ N

Regular Self Examination? (Breasts/Testicles) ☐ Y ☐ N

Routine Examinations: Vision: ☐ Y ☐ N Dental: ☐ Y ☐ N Hearing: ☐ Y ☐ N

Vaccination History:

Vaccine	Disease(s)	Received (Y/N)	Year (if known)	
Varicella	Chicken Pox			
DTaP	Diphtheria/Tetanus/Pertussis			10yr Booster:
Hep A	Hepatitis A			
Hep B	Hepatitis B			
MMR	Measles/Mumps/Rubella			
IPV	Polio			
RV	Rotavirus			
HPV	Human Papilloma Virus			
Meningitis	Meningitis			5yr Booster:
PCV13	Pneumococcal (Pneumonia)			
Zoster	Shingles			
Flu	Influenza			

Dietary Questionnaire

Name: ______________________________ **Date:** ____________________

Please describe what you eat for each of the items listed below:

Breakfast	
Morning Snack	
Lunch	
Afternoon Snack	
Dinner	
Evening Snack	
Sweets	
Beverages	

Estimated protein consumed each day: __________ grams

Estimated ounces of fluids consumed each day: __________ fl oz

Do you drink while you are eating? ☐ No ☐ Yes

Do you drink carbonated beverages? ☐ No ☐ Yes

Do you have any spit-ups or food that won't go down? ☐ No ☐ Yes How often? ____________________

Do you have frequent vomiting/nausea? ☐ No ☐ Yes How often? ____________________

Do you take all recommended vitamins? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes How often? ____________________

Any concerns that you would like to discuss today? ☐ No ☐ Yes

If yes, please describe: ____

____

____

Believe Bariatrics

PATIENT CONSENT, HIPPA, & ASSIGNMENT OF BENEFITS

I authorize the Physicians, Nurse Practitioners, Medical Assistants and other healthcare providers employed by **Believe Bariatrics and Primary Care** to provide medical care and medical treatment for me. I have provided **Believe Bariatrics and Primary Care** with all relevant information regarding my health history. I have informed **Believe Bariatrics and Primary Care** of all my known allergies. I have further informed of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use. I agree to keep **Believe Bariatrics and Primary Care** apprised of any changes in my medical condition or medications. I understand that it is important that I fully understand the medical care and treatment that I receive, and **Believe Bariatrics and Primary Care** that I may ask my healthcare provider any questions that I may have regarding any aspect of my medical care and treatment. I understand that it is my responsibility to actively participate in my care in order to maximize outcomes. I am aware and accept that there are no guarantees regarding the medical care and treatment being provided by the Physicians, Nurse Practitioners and other healthcare providers employed by **Believe Bariatrics and Primary Care.**

I authorize and affiliated entities to share my health information for the purpose of care and treatment. **Believe Bariatrics and Primary Care** or their affiliated service providers may also share my information with business associates with whom **Believe Bariatrics and Primary Care** has contracted to provide a specific business function. Their affiliated service providers may communicate with my Primary Care Physician and other treating healthcare providers that I have provided information about for my care and treatment. **Believe Bariatrics and Primary Care** may also use my telephone numbers, mailing addresses, or **Believe Bariatrics and Primary Care** email addresses to contact me in the future regarding health-related benefits or services. **Believe Bariatrics and Primary Care**

I understand and acknowledge that in some circumstances, **Believe Bariatrics and Primary Care** may file a claim with my health insurance as a courtesy to me and that I will be responsible for all billable services not covered by insurance. I am responsible for paying my co-payments at the time of service. If I do not have insurance benefits, I understand that I will be required to pay for the services myself. If benefits are not determined, I understand that I may elect to pay for services myself. In this case, **Believe Bariatrics and Primary Care** will not file a health insurance claim for me, but may provide me with information to file the claim myself. I have provided my complete, current, and accurate information about all insurance coverage. Should any information regarding my insurance change, I agree to notify **Believe Bariatrics and Primary Care** immediately. Payment is due at the time of service.

I agree to assign my health insurance benefits to **Believe Bariatrics and Primary Care** for the services rendered by **Believe Bariatrics and Primary Care** and its employees.

By signing below, I certify that I have read the above information. Any questions concerning the above information have been discussed. My signature also certifies my understanding and agreement with the above information.

Patient or Patient's Representative Signature:	
Date:	
Relationship to Patient:	

Believe

Allergy History - BASE Symptom Evaluation

Branson Allergy Symptom Evaluation (BASE)

COMPLAINTS: Please circle the appropriate number 0 to 3 according to severity:

0 = Absent (no symptoms evident)
1 = Mild (symptoms present, but minimal awareness)
2 = Moderate (symptoms present but tolerable)
3 = Severe (symptoms persistent and severe)

Symptom					Symptom				
Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itchiness	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itchy ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus and/or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Irritated eyes	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus Pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus Pain	0	1	2	3

Any other symptoms that bother you?

____

MEDICATIONS: How often do you take medication(s) for your allergy symptoms?

0 = Never
1 = Occasionally (several times a month or less)
2 = Frequently (several times per week)
3 = Daily

Medication					Medication				
Antihistamines	0	1	2	3	Nasal steroids (Flonase, Nasacort)	0	1	2	3
Oral steroids	0	1	2	3	Asthma medication (inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medication:	0	1	2	3

Does any medication give you complete relief of symptoms? ☐ Yes ☐ No

GENERAL ALLERGY HISTORY:

How many months of the year do you have allergies? ______ For how many years have you had allergies? ______

In what season(s) are they worse? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you been allergy tested before? ☐ No ☐ Yes – Type: ☐ Skin prick/puncture ☐ Blood Draw

Have you previously received allergy shots? ☐ No ☐ Yes – when? ____________

Have you previously received allergy drops? ☐ No ☐ Yes – when? ____________

Do you smoke or use tobacco/nicotine products? ☐ Yes ☐ No

List any animals you have in or around your home: ______________________________

Who else in your family has allergies? ______________________________

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ Date: ______________

OFFICE USE ONLY: Raw Score: __________/25 X 4 = ____________ **FINAL SCORE**

0 – 25 = MILD 26 – 50 = SIGNIFICANT 51 – 100 = SEVERE 100+ = VERY SEVERE