MedStar Franklin Square Medical Center

Patient Registration

Last name: _____First name:_____ Middle initial:_____

Date of Birth: _____ Social Security# _____

_____
Address

_____
City State Zip Code

Employer:_____ Occupation:_____

Emergency Contact Name:_____ Relation:_____

Phone: (day)_____ (evening)_____

Preferred methods of communication: Which phone number(s) do you prefer us to call?

Home phone # _____ Ok to leave voicemail ☐ YES ☐ NO

Work phone # _____ Ok to leave voicemail ☐ YES ☐ NO

Cell phone # _____ Ok to leave voicemail ☐ YES ☐ NO

When we mail information, may we use:

☐ Envelope with office return address ☐ Plain envelope ☐ DO NOT MAIL

Mailing address: (if different from above)

_____
Street Address City, State Zip code

Do you have trouble hearing or understanding information over the phone? ☐ Yes ☐ No

Would you like us to discuss your healthcare needs with a caregiver, family member, or significant other?

☐ Yes ☐ No

If yes: Name_____ Relationship:_____ Phone_____

May we discuss the following (check ALL items that apply)

☐ Appointments ☐ Billing Issues ☐ Medications ☐ All healthcare information

Who would you prefer us to leave a message with? ☐ DO NOT LEAVE A MESSAGE WITH ANYONE

Name_____ Relationship: _____Phone_____

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Insurance Coverage

Primary Insurance
Insurance Company:_____ Member ID:_____

Insurance Phone:_____ Group #:_____

Insurance Address:_____

Policy Holders Name;_____ Policy Holders Date of birth:_____

Secondary Insurance
Insurance Company:_____ Member ID:_____

Insurance Phone:_____ Group #:_____

Insurance Address:_____

Policy Holders Name;_____ Policy Holders Date of birth:_____

Patient's Authorization

I hereby authorize my insurance benefits to be paid to my physician. I certify the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.

This office will prepare insurance forms for covered services to assist in making collections from the insurance company. In an effort to keep our fees as low as possible, we find it necessary to expect our patients to pay for non-covered services they receive at the time of service.

This authorization may be revoked b y me at any time in writing. I understand that nothing herein relieves me of the primary responsibility to pay medical services provided, when a statement is redered.

_____ _____

Signature of Patient Date

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Financial Policy

The following is a statement of our Financial Policy in which we ask that you read and sign prior to any treatment. You will also be given a copy of the signed paper for you to refer to.

Patient Responsibilities:
Your insurance is a contract between you and your insurance company. You are responsible for ALL deductibles, co-pays, and coinsurance. We cannot "write off" any amount that is your responsibility. Please be aware that some and perhaps all of the services provided may be a non-covered service (or not considered "medically necessary") and are therefore your responsibility.

Co-pays and Balances:
Your co-pay is expected at the time of service. If you do not have your co-pay with you, we reserve the right to reschedule your appointment. You are responsible for any amount not covered by your insurance at the time or service, including office visit co-pays. If your insurance company has not paid your bill within 45 days, the balance will be billed to you. Balances will need to be paid in full prior to scheduling any follow0up appointments or procedures. You will be held responsible for collection and legal costs should it be necessary for this account to be turned over to a collection agency.

Referrals:
You are responsible for obtaining referrals from your primary care provider if required by your insurance company. You are also responsible for keeping track of the number of approved visits and the duration for which the referral remains valid. Our office staff is not required to call your doctor's office for you regarding your referral. If you come to the office without a referral, or with an expired referral, or with a referral with no more authorized visits on it, we have the right to reschedule your appointment.

Fees:
Form Fees: There will be a $15.00 fee per form that needs to be filled out by the doctor. You must allow at least five to seven business days for the completion of any form(s).
"No Show" Fees: We require 24 hours notice to cancel your appointment. You may be charged a $30 fee for not cancelling your appointment within 24 hours. Any patient missing three appointments within a 6 month period may result in dismissal of care. Consideration will be given to those with TRUE medical emergencies, illness, or death in the family.

I have read, understand, and agree to this financial policy.

Printed Name:_____

Signature:_____

Date:_____

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Patient Safety Screen

WE CARE ABOUT YOUR SAFETY!

Please help us by providing information about any safety issues you may have while under our care. For each section below, ***check ALL items that apply*** to you. You may provide an additional explanation in the line below each section.

INTAKE INFORMATION:

Preferred Language: ☐English ☐Spanish ☐Other_____

Communication Needs: ☐NONE ☐Interpreter Needed ☐Written Information ☐Interpreter ☐TTY ☐ASL

Education Level: ☐ High School ☐ College ☐ Other_____

Learning Preference: ☐No preference ☐Verbal ☐Visual ☐Written ☐Lip reading

Barriers to learning: ☐None ☐ Difficulty ☐Vision Impairment ☐Hearing Impairment ☐Learning disorder

Religious Preference: ☐None ☐Catholic ☐Christianity ☐Judaism ☐Islam ☐Buddhism ☐Hinduism ☐Jehovah's Witness

Advance Directives: ☐Written information provided ☐ Written information declined ☐ On file

Caregiver at home: ☐ NO ☐YES

Name of Caregiver: _____

Provider Names

In order to ensure appropriate coordination of care, please provide the names and phone numbers of any doctors you are currently seeing of have seen in the immediate past.

Primary Care Physician: Name: _____

Phone #_____

Referring Physician: Name:_____

Phone:_____

Any Other Physicians Currently Being Seen:

Physician Name: _____

Specialty: _____

Physician Name: _____

Specialty: _____

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Pharmacy : Name:_____

Location:_____

Phone Number:_____

Fax Number:_____

Allergies: ❒ Check if no allergies

Allergy	Type of reaction

Current medication (prescription and non-prescription): ❒ Check if no medications

Medication	Dosage	Times per Day	Purpose

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Medical History (❒ Check if no medical history

Cardiovascular Disease	Musculoskeletal
❒ Coronary artery disease	❒ Arthritis
❒ Congestive heart failure	❒ Fibromyalgia
❒ Deep venous thrombosis (clot in the leg)	❒ Musculoskeletal disease
❒ Pulmonary embolism (clot to the lung)	**Psychiatric**
❒ High blood pressure	❒ Bipolar disorder
❒ Lower leg swelling	❒ Anxiety/Panic disorder
❒ Peripheral vascular disease	❒ Personality disorder
❒ Stroke	❒ Psychosis
Gastrointestinal	❒ Depression
❒ Gallstones with symptoms	**Pulmonary**
❒ Reflux	❒ Asthma
❒ Liver disease	❒ Sleep apnea
General	❒ Emphysema/COPD
❒ Abdominal hernia	**Reproductive**
❒ Abdominal skin/pannus	❒ Polycystic Ovarian Syndrome
❒ Pseudotumor cerebri	❒ Menstrual Irregularities
❒ Stress urinary incontinence	**Other**
Metabolic	❒
❒ Diabetes mellitus	❒
❒ Thyroid Disorder	❒
❒ High cholesterol	❒

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Patient Name:_____

Patient Date of Birth:_____

Surgical History (check all that apply): ❒ Check if no surgical history

Surgery	Date	Comment
❒ Previous bariatric surgery		Type: Initial weight: Lowest weight achieved:
❒ Anti-reflux procedure		
❒ Appendectomy		
❒ Bowel resection		
❒ Breast cancer, biopsy		
❒ Breast cancer, mastectomy		
❒ Breast cancer, radiation		
❒ CABG		
❒ Cesarean section		Number:
❒ Gallbladder		Open / Laparoscopic
❒ Discectomy		
❒ Hip Replacement		
❒ Hysterectomy		
❒ Knee replacement		
❒ Laminectomy		
❒ Nissen fundoplication		
❒ Peripheral vascular procedure		
❒ Tubal Ligation		
❒ Vagotomy		
❒ Vasectomy		
❒ Hernia		Type:
❒ Other: (list surgeries and year)		

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Patient Name:_____

Patient Date of Birth:_____

Family History:

Relationship	Alive	Age	Health Problems	
Mother	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____
Father	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____
Maternal Grandmother	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____
Maternal Grandfather	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____
Paternal Grandmother	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____
Paternal Grandfather	❒ Yes ❒ No		❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ High Cholesterol ❒ Sleep Apnea ❒ Other:	❒ Degenerative Joint Disease ❒ Stroke ❒ COPD ❒ Obesity ❒ Cancer:_____

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Social History

Education: ❒ 9 to 11 years ❒ High School Graduate ❒ Vocational/ Technical ❒ Attended College ❒ College Graduate ❒ Post Graduate	Do you use nicotine? If yes, what kind: ❒ Cigarettes ❒ Cigars ❒ Chewing tobacco ❒ Vapor Former user: Date last used:	Yes ❒ No ❒ If yes, how much: Yes ❒ No ❒
Number of Children: ❒ None ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6	Do you drink alcohol? History of alcohol abuse: If yes, how much: ❒ Less than 2 per day ❒ Between 2 – 5 per day ❒ Between 6 – 10 per day ❒ More than 11 per day	Yes ❒ No ❒ If yes, how often: ❒ Daily ❒ Weekly ❒ Monthly ❒ Occasionally ❒
Religion: ❒ Atheist ❒ Christian ❒ Catholic ❒ Jewish ❒ Jehovah's Witness ❒ Muslim ❒ Other:	Do you use illegal drugs? History of drug abuse: If yes, what kind: ❒ Marijuana ❒ Cocaine ❒ Heroin ❒ Amphetamine ❒ Other:	Yes ❒ No ❒ If yes, how often: ❒ Daily ❒ Weekly ❒ Monthly ❒ Occasionally ❒

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Review of Systems (check all that apply)

GENERAL

- ❒ Weight gain
- ❒ Weight loss
- ❒ Fever
- ❒ Chills
- ❒ Night Sweats
- ❒ Heat or cold intolerance
- ❒ Excessive thirst
- ❒ Bleeding tendency
- ❒ Swelling of lymph nodes

HEAD

- ❒ Headaches
- ❒ Vertigo
- ❒ Lightheadedness

NECK

- ❒ Pain
- ❒ Stiffness
- ❒ Masses

EYES

- ❒ Visual changes
- ❒ Double vision
- ❒ Blind spots
- ❒ Redness
- ❒ Pain
- ❒ Eye irritation

EARS

- ❒ Decreased hearing
- ❒ Ringing in the ears
- ❒ Earache

NOSE

- ❒ Nosebleed
- ❒ Sinus problems
- ❒ Nasal discharge or post-nasal drip

MOUTH

- ❒ Cavities - untreated
- ❒ Dentures
- ❒ Sores/ulcers
- ❒ Change in voice

HEART

- ❒ Chest pain
- ❒ Palpitations
- ❒ Fainting
- ❒ Shortness of breath with exertion
- ❒ Difficulty breathing when lying flat
- ❒ Waking up from sleep unable to breathe
- ❒ Swelling in the lower legs
- ❒ Blue/purple skin discoloration
- ❒ Cramping of legs with walking

BREAST

- ❒ Lumps
- ❒ Tenderness
- ❒ Swelling

LUNGS

- ❒ Shortness of breath at rest
- ❒ Chest pain with deep breathing
- ❒ Wheezing
- ❒ Cough
- ❒ Blood in sputum
- ❒ Stopping of breathing during sleep

GASTROINTESTINAL

- ❒ Nausea and/or Vomiting
- ❒ Difficulty swallowing
- ❒ Heartburn
- ❒ Abdominal pain
- ❒ Jaundice (yellow skin discoloration)
- ❒ Vomiting of blood
- ❒ Constipation
- ❒ Diarrhea
- ❒ Blood in stool

MUSCULOSKELETAL

- ❒ Pain and swelling of the joints
- ❒ Back pain
- ❒ Leg cramps
- ❒ Restless leg

GENITOURINARY

- ❒ Urgency or frequency of urination
- ❒ Involuntary leakage of urine
- ❒ Decreased urinary stream
- ❒ Pain with urination

GENITOURINARY

- ❒ Frequent urination at night
- ❒ Blood in urine
- ❒ Foamy urine
- ❒ Frequent urination
- ❒ Unusually dark urine
- ❒ Flank or side pain
- ❒ h/o kidney stones
- ❒ Decreased sexual drive
- ❒ Impotence

SKIN

- ❒ Rash
- ❒ Itching
- ❒ Change in moles
- ❒ Change in nails
- ❒ Hair growth or loss

NEUROLOGIC

- ❒ Convulsions or seizures
- ❒ Loss of consciousness
- ❒ Numbness
- ❒ Weakness
- ❒ Memory loss
- ❒ Lack of muscle coordination
- ❒ Tremor

PSYCHIATRIC

- ❒ Anxiety
- ❒ Depression
- ❒ Hallucinations

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

MedStar Franklin Square Medical Center Bariatric Surgery Program

I am interested in the following procedure(s):

Roux-en-Y Gastric Bypass	❒
Sleeve Gastrectomy	❒
Lap-Band	❒
Conversion or Revision Surgery	❒

In your own words, please let us know why you are considering surgery:

Obstructive Sleep Apnea Screening Questionnaire:

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	❒ 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

Which of the following life events have been associated with significant weight change?

❒ Marriage	❒ Divorce/Separation	❒ Quitting smoking	❒ Medication use
❒ Death in the family	❒ Illness in the family	❒ New job	❒ Change in job
❒ Retirement	❒ Suffering from illness	❒ Pregnancy Year:	❒ Other: _____

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Patient Date of Birth:_____

Have you been diagnosed with an eating disorder?

❒ Compulsive overeating	❒ Binge eating	❒ Anorexia nervosa
❒ Bulimia	❒ Laxative abuse	❒ Other

If yes- current/past treatment: _____

Eating patterns

❒ I eat 3 meals per day	❒ I eat 1 or 2 meals per day	❒ I tend to skip meals
❒ I skip breakfast	❒ I eat just before bedtime	❒ I eat in the middle of the night
❒ I prepare my own meals	❒ I eat at my desk	❒ I eat at the dining table
❒ I eat in front of the TV	❒ I eat "on the run"	❒ I eat at a restaurant or cafeteria several times a week

Drinking patterns

Drink	❒ Yes ❒ No	How many cups per day?
Diet soda	❒ Yes ❒ No	
Regular soda	❒ Yes ❒ No	
Coffee	❒ Yes ❒ No	
Water	❒ Yes ❒ No	
Juice	❒ Yes ❒ No	
Alcohol	❒ Yes ❒ No	

Eating behaviors

Please check all situations that apply where you eat when NOT really hungry:		
❒ Bored	❒ Anxious	❒ Talking on the phone
❒ Emotional	❒ Stressed	❒ Watching TV
❒ Reading	❒ Tired	❒ Gathered with friends

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Please check all that apply:		
❒ I eat more rapidly than others around me	❒ I eat until feeling uncomfortably full	❒ I eat alone
❒ I feel depressed or guilty after overeating	❒ I feel that I cannot control the amounts of food I am eating	❒ I eat large amounts of food even when I am not hungry

Exercise and fitness

I participate in regular exercise:	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
I do resistance/weight training exercises:	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
I walk (*in addition to work/daily tasks*):	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
Cardio exercises (Running, Elliptical, Cycling):	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
Swimming:	❒ Never ❒ Daily ❒ Weekly ❒ Monthly
Sports/Recreational activities:	❒ Never ❒ Daily ❒ Weekly ❒ Monthly

What limits your ability to be more physically active?		
❒ Physical size	❒ Pain	❒ Uncertain how to exercise appropriately
❒ Lack of support	❒ Lack of motivation	❒ Lack of resources (equipment)

List the diets/programs you have tried:

Diet or weight loss medication	Year	Length in months	# pounds lost

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Lifestyle Changes

Do you feel you are ready to commit to and follow a healthy meal plan?	❒ Yes ❒ No
Do you feel you are ready to commit to an exercise program?	❒ Yes ❒ No
Do you feel you have the support (family/friends) you need to be successful?	❒ Yes ❒ No
Do you feel you will be able to perform the work to achieve your goals?	❒ Yes ❒ No
Do you feel you have the motivation and dedication to achieve your goals?	❒ Yes ❒ No

It is your responsibility to remain in contact with the program up to five years post-op. Please keep the office updated with contact changes to include contact numbers and current address along with insurance coverage.

_____ _____

Signature **Date**

MedStar Franklin Square Medical Center

Patient Name:_____

Patient Date of Birth:_____

Patient Testimonial Regarding Weight Loss

This is your chance to explain to your insurance company why you are a good candidate for Bariatric Surgery. Many people describe past attempts to weight loss, why they were unsuccessful, and describe in detail why bariatric surgery is their next step. <u>This is mandatory.</u>