

NORTH TEXAS BARIATRIC

Frank Veninga, MD

4333 North Josey Lane, Suite 207, Carrollton, Texas 75010

Phone 972-939-8218 Fax 972-395-1789

Today's Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
Street Address _____
City _____ State _____ Zip _____ Date of Birth _____
Home Phone (____) _____ Cell Phone (____) _____ email _____
Age _____ Gender _____ Ethnicity _____ Religion _____ Marital Status _____
Social Security _____ Driver's License # _____ State _____
Primary Care Physician Name: _____ Phone _____
Notify in an Emergency: _____ Relationship to patient _____ Phone _____

EMPLOYMENT

Employer Name _____
Employer Address (City, State Zip) _____
Work Phone (____) _____ Position _____ Status: Full Time / Part Time / Retired

INSURANCE

Name of Insurance Company _____ Type: HMO / PPO / POS / EPO
Street Address of Insurance Company _____
City _____ State _____ Zip Code _____
Phone(____) _____ Policy / ID # _____ Group# _____

INSURED PARTY INFORMATION (if different from patient)

Last Name _____ First Name _____ MI _____
Street Address _____
City _____ State _____ Zip _____ Date of Birth _____
Home Phone (____) _____ Gender _____ Social Sec. # _____ Driver's License # _____
Employer Name _____
Employer Address (Include City, State Zip) _____
Work Phone(____) _____ Position _____ Status: Full Time / Part Time / Retired
Patient Relationship to Insured Party: Self / Spouse / Child / Other _____

SECONDARY INSURANCE POLICY INFORMATION

Name of Insurance Company _____ Type: HMO/ PPO / POS / EPO/ Other
Claims mailing address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Policy/ ID # _____ Group# _____
Last Name _____ First Name _____ MI _____
Date of Birth _____ Age _____ Gender _____ Social Security _____ Driver's License # _____
State _____ Home Phone(____) _____ Cell Phone (____) _____

Please note that we must be notified of any changes to demographic changes in address, phone number, employment, and any changes in insurance information. Thank you

North Texas Bariatric & General Surgery

MEDICAL RELEASE

I authorize North Texas Bariatric to release medical information and/or test results to the following persons:

1. _____ Relationship: _____
2. _____ Relationship: _____

AUTHORIZATION RELEASE:

I verify the accuracy of the above information. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or referring physician. I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all co-payments, co-insurance amounts, and or services not covered by my insurance carrier for services rendered on my behalf or my dependents.

Please be advised: All new patient consultations require a \$25.00 fee for no-shows without a 24-hour notification.

Signature of patient _____

Date _____

Witness of Signature _____

North Texas Bariatric

Date _____ Patient Name _____

Where did you hear of North Texas Bariatric & General Surgery and Dr. Frank Veninga?

- _____ Internet Search
- _____ Physician Referral Doctor's Name: _____
- _____ Friend Name : _____
- _____ Family Member Name : _____
- _____ Yellow Pages
- _____ Click Ad
- _____ Newspaper
- _____ Television Ad
- _____ Other _____

Regarding insurance approval:

Would you like us to attempt to get approval for _____ LAP-BAND System, _____ Gastric Sleeve Resection
or _____ Realize Band System

Or Are you interested in paying cash for _____ Gastric Sleeve Resection
_____ LAP-BAND System
_____ Realize Band System

PHYSICIAN RECORDS

We will need to have your medical records before we can submit the request for approval to your insurance company. Without these medical records the probability of being approved for Weight Loss Surgery is greatly diminished. Please have pertinent records sent for care you have received in the past three years. (For patients with coverage by Aetna Insurance, the records need to go back for five years.) If you are having your doctor(s) send the records directly to our office (which generally saves you money, since very few doctors charge a patient to send their records directly to another physician), please list the doctors we should expect records from. If we do not know who to expect records from we may attempt to get insurance approval and turn out being denied because a critical piece of information was left out of the pre-determination letter because we did not know more records were coming.

DOCTORS TO EXPECT MEDICAL RECORDS FROM:

1. Doctor's Name _____ Phone Number _____
2. Doctor's Name _____ Phone Number _____
3. Doctor's Name _____ Phone Number _____
4. Doctor's Name _____ Phone Number _____

Primary Care Physician: _____

Street Address: _____

City/State/Zip _____

Phone: _____ FAX: _____

Previous attempts at weight reduction:

Height: _____ **Weight:** _____ How many years have you been overweight? _____

Diet programs and supplements: (Please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Weight Watchers	_____	_____	_____	_____
<input type="radio"/> Jenny Craig	_____	_____	_____	_____
<input type="radio"/> Metabolife	_____	_____	_____	_____
<input type="radio"/> Medifast	_____	_____	_____	_____
<input type="radio"/> Nutri/System	_____	_____	_____	_____
<input type="radio"/> Atkins Diet	_____	_____	_____	_____
<input type="radio"/> Herbalife	_____	_____	_____	_____
<input type="radio"/> SlimFast	_____	_____	_____	_____
<input type="radio"/> Grapefruit Diet	_____	_____	_____	_____
<input type="radio"/> Liquid Diets	_____	_____	_____	_____
<input type="radio"/> Pritikin Diet	_____	_____	_____	_____
<input type="radio"/> Optifast	_____	_____	_____	_____
<input type="radio"/> T.O.P.S.	_____	_____	_____	_____
<input type="radio"/> Other:	_____	_____	_____	_____

List any other physician-supervised

Weight loss attempts: _____

Weight-Loss Medication History: Please indicate if you have taken any of the following medications to lose weight.

Medication:	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Amphetamines	_____	_____	_____	_____
<input type="radio"/> Phentermine	_____	_____	_____	_____
<input type="radio"/> (Adipex, Fastin, Pondimin)	_____	_____	_____	_____
<input type="radio"/> Phen-Fen	_____	_____	_____	_____
<input type="radio"/> Dexfenfluramine (Redux)	_____	_____	_____	_____
<input type="radio"/> Xenical (Orlistat)	_____	_____	_____	_____
<input type="radio"/> Meridia (Sibutramine)	_____	_____	_____	_____

Other Diet Medications:

Non-Dietary Therapies: Please indicate if you have tried any of the following weight loss therapies.

Medication:	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Exercise	_____	_____	_____	_____
<input type="radio"/> Hypnosis	_____	_____	_____	_____
<input type="radio"/> Behavior Modification	_____	_____	_____	_____
<input type="radio"/> Acupuncture	_____	_____	_____	_____

List any other weight loss methods you have tried: _____

Previous Weight Loss Surgery: No Yes

Surgery Type	Date	Surgeon	Wt. Loss
_____	_____	_____	_____
_____	_____	_____	_____

Please bring a chronological diet history to your initial appointment

Sleep Difficulties:

- snoring No Yes
- awakenings at night No Yes
- daytime drowsiness No Yes
- observed apnea spells No Yes
- morning headaches No Yes

Reflux/Heartburn/Esophagitis/Hiatal Hernia No Yes

- If yes, year of diagnosis: _____
- Prescription medications: No Yes
- Over the counter meds: No Yes
- Frequency of use: _____
- Endoscopy: No Yes

Venous Stasis No Yes

- Leg or ankle swelling/edema No Yes
- Leg ulceration No Yes
- Leg skin color change or thickening No Yes

Pain or Arthritis of Ankles/Knees/Hips No Yes

- Limits ability to walk or exercise No Yes
- Prescription medications No Yes
- Over the counter medications No Yes

Low Back Pain / Sciatica No Yes

- Limits ability to walk or exercise No Yes
- Prescription medications No Yes
- Over the counter medications No Yes

Urinary Incontinence (leakage of urine) No Yes

- With coughing/sneezing/straining No Yes
- Number of times per week: _____

Migraine Headaches No Yes

- Frequency: _____
- Prescription medications No Yes
- Over the counter medications No Yes

Deep Venous Thrombosis (Blood Clots in Legs) No Yes

- If yes, year of diagnosis: _____
- Pulmonary embolism No Yes
- Blood thinning medication No Yes

Abdominal Wall Hernia No Yes

- Incisional No Yes
- Umbilical (belly button) No Yes
- Number of hernia repairs and dates: _____
- Hernia currently present _ No _ Yes

Menstrual Irregularities
Infertility

- No Yes
- No Yes n/a

Past Medical History:

Please list all other medical conditions or illnesses not previously mentioned:

Please list all non-surgical hospitalizations you have experienced as an adult:

Indication	Hospital	Date

Past Surgical History:

Please list all surgical procedures or operations:

Procedure	Indication	Hospital	Date

Family History: (Please indicate if family members have any of the following illnesses)

- | | | |
|---|---|---|
| <input type="radio"/> Obesity | <input type="radio"/> Lung disease or emphysema | <input type="radio"/> Kidney Disease |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> High Cholesterol | <input type="radio"/> Diabetes |
| <input type="radio"/> Heart Disease | <input type="radio"/> Breast Cancer | <input type="radio"/> Blood Disorder |
| <input type="radio"/> Stroke | <input type="radio"/> Other Cancers | <input type="radio"/> Bleeding Tendency |

Social History:

Marital Status: Single Married Divorced

Children: No Yes Number: _____

Occupation: _____

Do you smoke tobacco? No Yes

 If yes, number of packs per day: _____ Years of tobacco use: _____

Do you use alcohol? No Yes

 Amount and frequency: _____

Have you ever been treated for depression? No Yes

 Are you currently in treatment? No Yes

 If yes, please indicate the name of your physician or therapist:

Have you ever been hospitalized for mental illness? No Yes

System Review: (Please mark any of the following you experience or have experienced in the past.)

- Constitutional:**
- | | | |
|-------------------------------|------------------------------------|--|
| <input type="radio"/> fatigue | <input type="radio"/> tiredness | <input type="radio"/> recent weight loss |
| <input type="radio"/> fever | <input type="radio"/> night sweats | <input type="radio"/> abnormal bleeding |

- Head and Neck:**
- | | | | |
|---|--|--|---------------------------------------|
| <input type="radio"/> blurred vision | <input type="radio"/> double vision | <input type="radio"/> loss of vision | <input type="radio"/> loss of hearing |
| <input type="radio"/> dizziness | <input type="radio"/> vertigo | <input type="radio"/> sinus congestion | <input type="radio"/> runny nose |
| <input type="radio"/> sneezing | <input type="radio"/> loss of smell | <input type="radio"/> sinus infections | <input type="radio"/> sore throat |
| <input type="radio"/> difficulty swallowing | <input type="radio"/> pain when swallowing | <input type="radio"/> hoarseness | <input type="radio"/> lump in neck |

- Cardiovascular:**
- | | | | |
|---|--|------------------------------------|------------------------------------|
| <input type="radio"/> chest pain | <input type="radio"/> pain in arms or neck | <input type="radio"/> heart attack | <input type="radio"/> palpitations |
| <input type="radio"/> heart pounding | <input type="radio"/> abnormal heart beats | <input type="radio"/> heart murmur | <input type="radio"/> stroke |
| <input type="radio"/> high blood pressure | <input type="radio"/> low blood pressure | <input type="radio"/> pain in legs | <input type="radio"/> cold feet |
| <input type="radio"/> loss of pulses | | | |

- Respiratory:**
- | | | | |
|--|---|---------------------------------|----------------------------------|
| <input type="radio"/> shortness of breath | <input type="radio"/> asthma | <input type="radio"/> wheezing | <input type="radio"/> cough |
| <input type="radio"/> bloody sputum | <input type="radio"/> emphysema | <input type="radio"/> pneumonia | <input type="radio"/> bronchitis |
| <input type="radio"/> difficulty sleeping flat | <input type="radio"/> waking at night short of breath | | |

- Gastrointestinal:**
- jaundice
 - nausea
 - constipation
 - change in stool size
 - hepatitis
 - heartburn
 - pain with bowel movements
 - hemorrhoids
 - cirrhosis
 - abdominal pain
 - irritable bowel
 - vomiting
 - diarrhea
 - blood in stool
 - colitis
- Genitourinary:**
- blood in urine
 - trouble starting urine
 - frequent urination
 - kidney stones
 - leakage of urine
 - kidney infection
 - pain with urine
 - bladder infection
- Men:**
- discharge from penis
 - loss of erection
- Women:**
- vaginal discharge
 - abnormal vaginal bleeding
 - irregular periods
 - pelvic examination/PAP smear with past year
- Musculoskeletal:**
- pain in joints
 - pain in hips
 - low back pain
 - numbness in feet or legs
 - muscular aches
 - pain in knees
 - sciatica
 - swelling of joints
 - pain in ankles
 - herniated disk
 - abnormal lumps or masses
 - arthritis
 - pain in feet
- Endocrine:**
- hyperthyroid
 - previous radiation
 - previous steroid (corticosteroids, cortisone) use or injections
 - low thyroid
 - adrenal gland tumor
 - goiter
 - swollen glands
 - diabetes
- Skin/Breast:**
- skin cancer
 - breast mass
 - abnormal moles
 - nipple discharge
 - burns
 - mammogram within the past year
 - rash
- Neurological:**
- seizures
 - light headedness
 - tremors
 - convulsions
 - falling
 - loss of consciousness
 - fainting
 - muscle weakness
 - strokes
 - dizziness
 - numbness
- Psychological:**
- depression
 - suicidal thoughts
 - psychiatric or psychological counseling
 - anorexia
 - nervousness
 - suicide attempts
 - bulimia
 - anxiety
 - hospitalization for emotional problems
 - schizophrenia
 - binge eating

Physician Attestation: I have reviewed and verified the above information :

Please be advised: All new patient consultations require a \$25.00 fee for no-shows without a 24-hour notification.

Patient Signature: _____ Date: _____