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Date ____/____/____ Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Patient _____
Last First Middle Initial Preferred Name

Email _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ DOB ____/____/____ Single Married Widowed Separated Divorced

Social Security # _____ Ethnicity: ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Other

Who Refered You: _____ Primary Language _____

EMPLOYER	Company Name _____ Occupation _____ Address_____ Phone _____ Full-time Part-time City _____ State_____ Zip_____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birth date ____/____/____ SSN _____ Last First Middle Initial Employers Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State_____ Zip_____ Full-time Part-time
PATIENT INSURANCE PRIMARY	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have. Insurance Company Name _____ Policy/Group # _____ Effective Date ____/____/____ Name of Insured _____ ID # _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have. Insurance Company Name _____ Policy/Group # _____ Effective Date ____/____/____ Name of Insured _____ DOB ____/____/____ ID # _____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of auto accident, work-related injury or other personal injury someone else might be legally liable for? ❑ Yes ❑ No Your Initials** _____ If you answered yes, please fill out accidents specific form, available at the front desk. Pregnant: ❑ Yes ❑ No Pacemaker: ❑ Yes ❑ No Family Physician _____ Person to contact in case of emergency (Name and Phone#) _____ Attorney _____ Phone _____ Address _____

PERSONAL HISTORY

Patient Name	Date of Birth	Age	Today's Date

Did a physician send you to our office? ❑ YES ❑ NO

If yes, Who?

Are you currenty having any pain? ❑ YES ❑ NO

Where?

If so, how severe is your pain? 10 being the worst. (Please circle one) 1 2 3 4 5 6 7 8 9 1 0

Who is your primary care physician?

Reason for today's visit

Are you R or L hand dominate?

Occupation	Marital Status ❑ S ❑ M ❑ D ❑ W *(Please ✔one of the above)*	How many children do you have?

Do you smoke? ❑ Formerly ❑Currently ❑ Never ❑ Heavy ❑ Light # of years _____ (Quit, when? _____)

Alcohol Consumption: ❑ Formerly ❑Currently ❑ Never ❑ Heavy ❑ Light

Do you use drugs ❑ Formerly ❑Currently ❑ Never ❑ Heavy ❑ Light

FAMILY HISTORY (Has any of your immediate relatives ever had any of the following)

	YES	NO		YES	NO		YES	NO
Asthma	❑	❑	Breast Cancer	❑	❑	Sickle Cell Disease	❑	❑
Bleeding Disorder	❑	❑	Colon Cancer	❑	❑	Stroke/Mini Stroke	❑	❑
COPD/Lung Disease	❑	❑	Other Cancer _____	❑	❑	Thyroid Disease	❑	❑
Deep Vein Thrombosis	❑	❑	Heart Disease	❑	❑	Other _____	❑	❑
Depression	❑	❑	High Blood Pressure	❑	❑			
Diabetes	❑	❑	Kidney Disease	❑	❑			

Date of Last Menstrual Period: _____ (If applicable) _____

PAST MEDICAL HISTORY (Do you have or have you had any of the following)

	YES	NO		YES	NO		YES	NO
High Blood Pressure	❑	❑	Pulmonary Embolism	❑	❑	Kidney Failure	❑	❑
Heart Attack	❑	❑	Emphysema	❑	❑	Kidney Infections	❑	❑
Heart Failure	❑	❑	Sickle Cell Disease	❑	❑	Cirrhosis	❑	❑
Cardiovascular Disease	❑	❑	Pneumonia	❑	❑	Hepatitis	❑	❑
Carotid Artery Disease	❑	❑	Epilepsy	❑	❑	Stomach Ulcer	❑	❑
Peripheral Vasc Disease	❑	❑	Diabetes	❑	❑	Hiatal Hernia	❑	❑
Blood Clot	❑	❑	Thyroid Disease	❑	❑	Barrett's	❑	❑
Varicose Veins	❑	❑	Gout	❑	❑	Breast Cancer	❑	❑
Deep Vein Thrombosis	❑	❑	Acid Reflux Disease	❑	❑	Colon Cancer	❑	❑
Mitral Valve Prolaspe	❑	❑	Peptic Ulcer Disease	❑	❑	Lung Cancer	❑	❑
Bypass Surgery	❑	❑	Hyperthyroidism	❑	❑	Prostate Cancer	❑	❑
Stroke/Mini Stroke	❑	❑	Hypothyroidism	❑	❑	Bladder Cancer	❑	❑
Seizures	❑	❑	Liver Disease	❑	❑	Other Cancer _____	❑	❑
Migraines	❑	❑	Tuberculosis	❑	❑	Crohn's/UC	❑	❑
Elevated Cholesterol	❑	❑	Glaucoma	❑	❑	Colon Polyp	❑	❑
Asthma	❑	❑	Cataracts	❑	❑	HIV/AIDS	❑	❑
COPD	❑	❑	Depression	❑	❑	Others _____		
Lung Disease	❑	❑	Kidney Stone (s)	❑	❑			
Respiratory Disorder	❑	❑	Kidney Disease	❑	❑			

PAST SURGICAL HISTORY

	DATE		DATE
❑ Heart Angioplasty		❑ Organ Transplant	
❑ Heart Bypass/Valve		❑ What Organ (s)	
❑ Hernia Repair		❑ Tonsillectomy	
❑ Gallbladder Removed		❑ Appendectomy	
❑ Neck Surgery		❑ Abdominal Surgery	
❑ Back Surgery		❑ Cardiac Pacemaker	
❑ Bladder Surgery		❑ Joint Replacement	
❑ Kidney surgery			*Name Joint*
❑ Prostate Surgery		Other	
❑ Cancer Surgery			
❑ Cancer location			

REVIEW OF SYSTEMS (Do you have now or have you ever had any problems related to the following body systems)

	YES	NO
CONSTITUTIONAL		
Good general health lately	❑	❑
Appetite/Wt Change	❑	❑
Weakness/Fatigue	❑	❑
Fever/Chills	❑	❑
Headaches	❑	❑
Night Sweats	❑	❑
Insomnia	❑	❑
EYES		
Vision Change	❑	❑
Contacts/Glasses	❑	❑
Eye Disease or injury	❑	❑
Glaucoma	❑	❑
Recent Head injury	❑	❑
Neck pain/swelling/stiffness	❑	❑
ENT		
Hearing Loss	❑	❑
Ringing in ears	❑	❑
Earaches or drainage	❑	❑
Sinus problems	❑	❑
Nose bleeds	❑	❑
Mouth sore	❑	❑
Bleeding gums	❑	❑
Bad breath or bad taste	❑	❑
Sore throat or voice change	❑	❑
Swollen glands in neck	❑	❑
CARDIOVASCULAR		
Heart Trouble	❑	❑
Chest Pain/Angina	❑	❑
Sudden heart beat changes	❑	❑
Varicose Veins	❑	❑
Light Headedness	❑	❑
Dizziness	❑	❑
Swelling in limbs/Ankles/feet	❑	❑
Orthostatic Symptoms	❑	❑
Hoarseness	❑	❑
RESPIRATORY		
Shortness of Breath	❑	❑
Cough / Asthma /Wheezing	❑	❑
Spitting up blood	❑	❑
GASTROINTESTINAL		
Loss of Appetite	❑	❑
Indigestion/Heartburn	❑	❑
Abdominal Pain	❑	❑
Change in Bowel Habits	❑	❑
Nausea/Vomiting	❑	❑
Frequent diarrhea	❑	❑
Painful bowel movements	❑	❑

	YES	NO
GASTROINTESTINAL Con't		
Constipation	❑	❑
Blood in stools	❑	❑
Stomach pain	❑	❑
GENITOURINARY		
Frequent Urination	❑	❑
Burning /Painful Urination	❑	❑
Blood in Urine	❑	❑
Urinary Tract Infection	❑	❑
Bladder Control Problems	❑	❑
Change of force of strain when urinating	❑	❑
Incontinence or dribbling	❑	❑
Kidney stones	❑	❑
Possible Pregnancy	❑	❑
MUSCULOSKELETAL		
Back pain	❑	❑
Joint pain	❑	❑
Joint stiffness or swelling	❑	❑
Weakness of muscles or joints	❑	❑
Muscle pain or cramps	❑	❑
Claudication	❑	❑
Cold extremities	❑	❑
Difficulty in walking	❑	❑
Decreased range of motion	❑	❑
Elbow/Wrist/Hip/Foot pain	❑	❑
Leg Weakness	❑	❑
GENITOREPRODUCTIVE		
Decreased Sexual Drive	❑	❑
Sexual Dysfunction	❑	❑
Sexual difficulty	❑	❑
SKIN		
Skin sores or ulcers	❑	❑
Skin thickening	❑	❑
Rash or itching	❑	❑
Change in skin color	❑	❑
Change in hair or nails	❑	❑
Varicose veins	❑	❑
Breast problems	❑	❑
NEUROLOGICAL		
Frequent or recurring headaches	❑	❑
Light headed or dizzy	❑	❑
Convulsions or seizures	❑	❑
Numbness or tingling sensations	❑	❑
Tremors	❑	❑
Paralysis	❑	❑
Stroke	❑	❑
Head injury	❑	❑

	YES	NO
PSYCHIATRIC		
Hallucinations	❑	❑
Panic attacks	❑	❑
Memory loss or confusion	❑	❑
Nervousness	❑	❑
Depression	❑	❑
Sleep problems	❑	❑
ENDOCRINE		
Central Obesity	❑	❑
Glandular or hormone problem	❑	❑
Thyroid disease	❑	❑
Diabetes	❑	❑
Excessive thirst or urination	❑	❑
Heat or cold intolerance	❑	❑
Dry skin	❑	❑
Change in hat or glove size	❑	❑
HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	❑	❑
Easily bruise or bleed	❑	❑
Anemia	❑	❑
Phlebitis	❑	❑
Petechiae	❑	❑
Past transfusion	❑	❑
Enlarged glands/nodes	❑	❑
ALLERGIC/IMMUNOLOGIC		
History of skin reaction or other adverse reactions to:		
Penicillin or other antibiotics	❑	❑
Morphine, Demerol or other narcotics	❑	❑
Novocain or other anesthetics	❑	❑
Aspirin or other pain remedies	❑	❑
Tetanus antitoxin or other serums	❑	❑
Iodine, mentholated or other antiseptic	❑	❑
Other drugs/medications	❑	❑
Known food allergies	❑	❑

MEDICATION LIST

Patient Name _____ Date of Birth _____ Today's Date _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Benefit Manager (PBM) Consent: _____

LIST ALL MEDICATIONS WHICH YOU TAKE REGULARLY			
MEDICATION	**STRENGTH**	**ROUTE**	**FREQUENCY**

ALLERGIES (List all drugs to which you are allergic & type of reaction: such as rash, hives, shortness of breath)

Pharmacy Benefit Managers (PBM) Consent:

By signing the above consent I give permission to Sterling Center Bariatrics, to access my pharmacy benefits data electronically through RxHub. This consent will enable Sterling Center Bariatrics to determine co-pays; check coverage of a required medication under a patients plan; determine if patient health plan allows electronic mail orders; and download a histories list of all medications prescribed for a patient by provider.

_____ _____

Signature of Patient Date

PATIENT AGREEMENT AND OFFICE POLICIES

CREDIT POLICY
Charges for medical services in the office are due and payable at the time services are rendered.

EMERGENCIES:
There is always a physician on call for emergency care. If you have an emergency, please call the office at 229-289-1517 during office hours before driving to the emergency room. Your call will alert the office to your problem and will minimize delays in the hospital emergency room.

PRESCRIPTION REFILLS:
Prescription changes or refills are made during office hours to allow time to locate and evaluate your records. Please have your pharmacy send a refill request. No refills are available at night or on the weekends.

INSURANCE
If you have health insurance, our office will gladly file your claim for you, however, it should be understood that YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR DOCTOR'S BILL IS AN AGREEMENT BETWEEN YOU AND YOUR PHYSICIAN. You are responsible for your bill regardless of the status of your insurance claim. Insurance companies, according to their contracts, have a schedule of fees, which they will pay. Your doctor's fees may be more or less than the schedule of your insurance company. YOU ARE DIRECTLY RESPONSIBLE FOR YOUR ACCOUNT IRRESPECTIVE OF YOUR INSURANCE SCHEDULE.

INSURANCE APPEALS:
Should your insurance disallow or deny any part of your claim our office will appeal the decision at the patient's request. There will be a charge for this appeal based on the amount of time involved with gathering data, copying records, follow-up phone calls, etc. *Note: The patient will remain responsible for the balance of the account regardless of the appeals process. If the insurance carrier makes additional payment after the appeal that portion of the patient's payment will be refunded.

RETURNED CHECK:
Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month. If unusual circumstances should make it impossible to meet your obligation, please talk to our financial representative. She will be glad to assist you with arrangements for making payments. If you have any questions about the above information, please call 229-289-1517 we will be glad to assist you.

MISSED APPOINTMENTS:
Please notify our office at least 24 hours in advance of any appointment you are unable to keep. This allows us to see other patients who are waiting to be seen. Our policy is after 3 missed appointments you will be discharged from the practice.

LATE ARRIVAL:
Patients arriving more than 15 minutes after appointment time will be asked to reschedule. This will assure that the physician has enough time to give to the late patient without taking away time from the other scheduled patients.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS
In considering the amount to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned and hereby assign and convey directly to Sterling Center Bariatrics all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim I hereby authorize and plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I certify that I have accurately answered the above questions to the best of my knowledge. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician any monies due. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

_____ _____/_____/_____
Signature of Insured / Guardian Date

GENERAL HEALTH OVERVIEW

Patient Name _____ Date of Birth _____ Today's Date _____

Your overall general health is very important. Please answer the following questions so that we might know what additional services you might need now or in the future.

ALL PATIENTS COMPLETE THIS PORTION **COMMENTS**

Yes No

- ❑ ❑ Have you had a colonoscopy in the last 10 years? _____
- ❑ ❑ Do you currently use any type of tobacco (cigarettes, pipe, chewing, etc.) _____
- ❑ ❑ Do you have any moles, lesions, or skin tags for us to look at today? _____
- ❑ ❑ Have you had a screening "lipid" blood test in the last 5 years? _____

MALE PATIENTS ONLY

- ❑ ❑ Have you had a prostate exam in the last 12 months? _____
- ❑ ❑ Have you had a blood test for prostate cancer in the last 12 months? _____

FEMALE PATIENTS ONLY

- ❑ ❑ Do you do monthly self-breast exams? _____
- ❑ ❑ Have you had a breast exam by a physician in the last 12 months? _____
- ❑ ❑ Is there a possibility that you are pregnant? _____
- ❑ ❑ Do you have a history of sexually transmitted disease (including HIV) infection? _____
- ❑ ❑ Have you had a mammogram in the last 12 months? _____
- ❑ ❑ Have you had a bone density test (DEXA) in the last 24 months? _____

What are three questions you'd like to ask your doctor about today's visit?

1. _____
2. _____
3. _____

Patient's Signature:_____ Date _____

STERLING CENTER BARIATRICS

Acknowledgment of Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice

I understand that the providers of Sterling Center Bariatrics are part of an organized healthcare arrangement. These providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organizations notice of privacy that describes how my health information is used and shared. I understand Sterling Center Bariatrics have the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Official at 229-289-1517.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative **Date**

*If signed by legal representative, relationship to patient:*_____

Internal Use:

Written Acknowledgment was not obtained based on the following circumstance:

- ❑ **Patient Refused to sign**
- ❑ **Emergency Situation**
- ❑ **Unable to communicate with Patient**
- ❑ **Other:**_____

_____

_____ _____

Signature of Office Representative **Date**

Contact Authorization

I authorize staff of Sterling Center Bariatrics to contact me regarding appointment reminders, payment and lab/test results using the following methods I have checked below:

- ❑ Telephone (_____)_____/_____, (_____)_____/_____
- ❑ If I am not available, I authorize representatives of Sterling Center Bariatrics to leave a message on the answering machine or voice mail at the telephone numbers listed above.
- ❑ I authorized representatives of Sterling Center Bariatrics to leave messages concerning the aforementioned items with the following individual (s) _____
- ❑ U.S. Mail
- ❑ Other:

_____ _____

Patient/Authorized Representative Signature Date

Consultation/Referral Form

Patient Name: _____ Race: _____ DOB: _____

SS#: _____/_____/_____ Telephone: _____ Cell: _____ Work:_____

Mailing Address: _____

Primary Insurance: _____ Policy#: _____

Auth # for Medicaid/Wellcare/Tricare: _____ Email: _____

Patient's Diagnosis/Conditions/Signs/Symptoms: _____

How long has patient had this problem:_____

Is this visit covered by workers' compensation? _____

If so, Claim #:_____

InsuranceCo.Name:_____Case-worker:_____Phone#:_____

Also, written authorization of workers' compensation for specified service will be required.

Referring Physician: _____ Phone #: _____ NPI: _____

Referring Physician Fax#: _____

- ❑ Requesting a Consultation: Requesting provider is asking for the opinion, advice, recommendation, suggestion, direction, or counsel, in evaluating or treating this patient. The requesting provider understands that consulting physician may initiate diagnostic services and treatment at the time of the initial appointment. Requesting provider will receive a written report outlining the consultants' opinion and advice regarding this patient.

- ❑ Requesting a Referral: Referring provider is sending patient to Sterling Center Bariatrics for treatment only and is not seeking the opinion and/or advice of the consulting physician. Referring provider will not receive a written report pertaining to this patient's care.

Attention: Non-English speaking patients are responsible for bringing a translator.

Please keep this document in your chart as a part of your Plan of Care. Please fax insurance cards and all records including office notes, labs, x-rays, or other diagnostic studies at time consult is requested. Patient should arrive 30 minutes early to fill out new patient information or they may come by the office to pick it up.