

PATIENT REGISTRATION FORM

(Please Print)

Name: _____
LAST FIRST MI

Street Address: _____
STREET APT # CITY STATE ZIP

Home Phone #: () _____ Cell Phone #: () _____

Social Security: _____ - _____ - _____ Birth date: _____ Age: _____ Sex: M F

Marital Status: S M W D Ethnicity: _____ E-Mail address: _____

How Did You Hear About BSC Dallas? _____

Employment Status: ___ Full Time ___ Part Time ___ Self Employed ___ Homemaker ___ Student ___ Retired ___ Disabled ___ Unemployed

Employer: _____ Occupation: _____

Employer Address: _____ Business Phone #: () _____

Spouse Name: _____ Birth date: _____

Employer: _____ Business Phone #: () _____

Emergency Contact Information:

Name: _____ Home Phone #: () _____

Address: _____ Other Phone #: () _____

Relationship: ___ Spouse ___ Partner ___ Friend ___ Parent ___ Other _____

Referring Physician:

Name: _____ Specialty: _____ Phone Number: _____

Health Insurance Information:

Primary Insurance Co: _____ Phone #: _____

ID#: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder SS#: _____ Birth date: _____

Secondary Insurance Co: _____ Phone #: _____

ID#: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder SS#: _____ Birth date: _____

ASSIGNMENT OF BENEFITS, BOLD AGREEMENT, & SIGNATURE ON FILE

I authorize direct payment to Dr. James Davidson. I authorize the use of this form for all insurance submissions, and permit a copy of this to be used in place of the original. I authorize this provider to act as my agent in helping me obtain payment from my insurance company. I expressly revoke all prior revocations of any assignment of benefits. In the event that my current policy prohibits direct payment to the provider, then I hereby instruct and direct you to make out the check to me and mail in care of the Named provider. I certify that all the information is true and correct to the best of my knowledge. I will notify you of any changes in my health, the above information, or any other information. I understand that I am responsible for fees of any services rendered to me, regardless of any insurance or financial class. I understand that Dr. Davidson's office uses a service to check benefits, predetermination, pre-certification, and file insurance claims.

YES NO - I authorize the use of my information to be entered into a secure national database (BOLD), in compliance with the Centers of Excellence requirements. I understand that my information will remain private and is only to be used for national statistics and studies as they relate to bariatrics.

Signature: _____ Date: _____

PATIENT HISTORY/REVIEW OF SYSTEMS

Patient Name: _____ Date of Birth: _____ Age: _____

Current Medications:

Medication	Dosage	Frequency	Reason

Drug Allergies/reaction: _____

Previous Surgeries: (Please list all operations and surgical procedures)

Procedure	Date	Location	Reason

Family History: (Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Stroke								
Early Death								

Patient Name: _____ Date of Birth: _____ Age: _____

Social History:

Do you use tobacco: ___ yes ___ no
Packs per day _____
Age started _____
Age quit _____

Do you drink caffeine: ___ yes ___ no
Type: _____
Amount per day: _____

Do you drink alcohol ___ yes ___ no
Amount _____
Frequency _____

Eating style (mark all that apply):
Big eater _____ Sweets _____
Snacker _____ Grazer _____

Have you ever been treated for depression/anxiety: ___ yes ___ no
Are you currently in treatment: ___ yes ___ no

Medical/System Review (please check all that apply)

General

___ Fatigue
___ Tiredness
___ Unintentional Weight Loss
___ Recent fever
___ Night Sweats

Head and Neck

___ Blurred/double vision
___ Loss of vision
___ Sinus/allergy problems
___ Runny nose
___ Sneezing
___ Loss of Smell
___ Sore Throat
___ Difficulty Swallowing
___ Hoarseness

Cardiovascular

___ Chest Pains
___ Previous Heart Attack
___ Heart pounding/palpitations
___ Heart murmur
___ Pain in legs
___ Cold feet
___ Low blood pressure
___ High blood pressure
___ Abnormal heart beat
___ Elevated cholesterol
___ Elevated triglycerides
___ Previous Blood Transfusions

Respiratory

___ Shortness of Breath
___ Asthma
___ Wheezing
___ Coughing
___ Bloody sputum
___ Emphysema
___ Pneumonia
___ Bronchitis
___ Problems laying flat
___ Waking at night
___ CPAP/BIPAP

Gastrointestinal

___ Jaundice
___ Hepatitis
___ Cirrhosis
___ Fatty liver
___ Nausea (persistent)
___ Vomiting (persistent)
___ Stomach pain
___ Diarrhea
___ Constipation
___ Blood in stools
___ Irritable Bowel
___ Colitis

Genitourinary

___ Blood in urine
___ Frequent urination
___ Leakage of urine
___ Trouble starting urine

Musculoskeletal

___ Painful/swollen joints
___ Gout
___ Muscle aches
___ Arthritis
___ Pain in hips
___ Pain in knees
___ Pain in ankles
___ Pain in feet
___ Low back pain
___ Herniated disk
___ Sciatica
___ Weakness

Neurological

___ Seizures
___ Fainting
___ Dizziness
___ Vertigo
___ Falling
___ Numbness
___ Tingling
___ Tremors
___ Headaches
___ Migraines

Psychological

___ Depression
___ Anxiety
___ Nervousness
___ Suicide thoughts
___ Suicide Attempts

Endocrine

___ Hyperthyroid
___ Hypothyroid
___ Goiter
___ Any radiation
___ Diabetes
Type: _____
___ Adrenal tumors
___ Steroid use

Skin

___ Skin cancer
___ Rash
___ Eczema
___ Psoriasis
___ Burn scars
___ Other

Women

___ Menses regular
___ Menses irregular
___ Post menopausal
___ # of pregnancies
___ # of children

Reviewed by: _____

Date: _____

Weight Loss History

Patient Name: _____ Date of Birth: _____ Age: _____

How many years have you been overweight? _____

Have you had previous weight loss surgery? _____ no _____ yes

Procedure: _____ Date: _____

Diet Programs Previously Attempted

Program	Number of times attempted	Date of most recent attempt	Medically supervised	Amount of weight lost
Calorie/Carb counting				
Weight Watchers				
Richard Simmons				
Jenny Craig				
Nutri-System				
South Beach				
Slim Fast				
Atkins				
Optifast				
Medifast				
Herbalife				
Metabolife				
Other:				

Weight Loss Medication History

Medication	Number of times attempted	Date of most recent attempt	Medically supervised	Amount of weight lost
Amphetamines				
Phentermine				
Phen-Fen				
Redux				
Xenical				
Meridia				
Alli				
Other:				

Non Dietary or Medication Weight Loss Therapies

Therapy	Number of times attempted	Date of most recent attempt	Medially supervised	Amount of weight lost
Regular exercise				
Hypnosis				
Behavior modification				
Acupuncture				
Other:				

James A. Davidson, M.D., F.A.C.S.

8210 Walnut Hill Lane #513

Dallas, Texas 75231

Attention: Linda Leedy

214-696-2890

Fax: 214-373-6735

**AUTHORIZED
RELEASE OF PROTECTED MEDICAL INFORMATION**

**FROM THE:
MEDICAL OFFICE OF:** _____
(Name of Physician sending records)

OFFICE #: _____ **Fax #:** _____

Please provide a copy of the medical records listed below by means of facsimile or mail for the person listed below to Dr. James A. Davidson, at the address or fax number listed on this form.

Patient: _____ **Date of Birth:** _____

Address: _____ **Last 4 digits of Social Security #:** _____

_____ **City** _____ **State** _____ **Zip** _____

THE INFORMATION COVERED BY THIS AUTHORIZATION INCLUDES:

- Most recent History and Physical by primary care physician
- Most recent CBC, LIPID, CMP, LIPID
- Records regarding weight loss attempts within the past 2 years including medications, behavior modification, with documented weight at each visit.
- Documented weight for past 5 years (one chart note for each year showing weight)

2008	2007	2006	2005	2004	2003
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- Letter of Medical Necessity from treating physicians
- Documentation of any other health conditions made worse by obesity
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I understand that I may revoke or terminate this authorization by submitting a written revocation to BSC Dallas. For any questions or to terminate this authorization contact Linda Leedy at 214-696-2890.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's representative.

Signature of Patient

Signature of Patient Representative

Name of Patient (Printed)

Relationship of Representative to Patient

Date

Date