Glenn M. Ihde, MD, PA   Ihde Surgical Group PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

YOUR NAME: ____

PRIMARY CARE DOCTOR: _____________REFERRING DOCTOR: __________

HOSPITAL WHERE YOU WERE SENT FROM: ______________________________

Please describe briefly in your own words

1) what **symptoms** you experienced on what date and /or how often they occurred

____

____

____

2) and any **tests or x-rays** done

____

____

____

3) and **medications** prescribed for this illness:

____

____

____

Please list all surgeries/operations you have had:

Date	Operation performed	Reason	Hospital/Doctor

Are you **allergic** to any medications Y___ N ___ List: __________________

____

Please list all **medications** that you take:

Medication	Used for?	Dosage	(# per day)

Do you **smoke**? _____Yes _____No Yes (but quit in year________)

How many packs per day do you smoke? _____ How many years? _____

Do you drink **alcohol**? _____Yes _____No Yes (previously but sober since ___)

Answer: beer __#per day/week/weekend wine or liquor __#per day/week/weekend

(Please fill out in black ink)

Have you ever received a **BLOOD TRANSFUSION**? NO _____ YES _____

If YES, please describe: ____

please provide GYN history: #pregnancies __ #live births __ :(#vaginal __ and/or #C-section ___)

Dates of live births____

Last menstrual period _________ birth control: _____ tubal ____ pills ____ other

Year of menopause _____ year if hysterectomy (partial) or (total)

On hormone replacement therapy since ______

FAMILY HEALTH HISTORY: if known, please identify any of these illnesses in close family members such as:

<u>Circle disease below and check blank</u>	grandparents	parents	brothers	sisters	children
Cancer of (breast), (prostate) (testicle)	__________	______	______	______	_______
Cancer of (colon), (stomach),(liver), (pancreas)	__________	_____	______	______	_______
Cancer of (vagina), (cervix), (uterus), (ovary)	__________	_____	______	______	_______
(Leukemia), (Lymphoma)	__________	_____	______	______	_______
(High blood pressure)	__________	_____	______	______	_______
(Diabetes)	__________	_____	______	______	_______
(Heart attack), (Stroke)	__________	_____	______	______	_______

OWN HEALTH HISTORY: Do you have or have you ever had any of the following (indicate dates):

<u>Circle illness</u>	<u>Diagnosed</u>	<u>Treated</u>	<u>Hospitalized</u>
Diabetes			
High blood pressure			
Angina/heart attack/heart murmur			
Heart failure/feet swelling			
Irregular heart beat/pacemaker			
Heart bypass or angioplasty			
Asthma/emphysema			
Tuberculosis/pneumonia			
Seizures/stroke/carotid artery surgery			
Migraine or severe headaches			
Hepatitis A B C/ cirrhosis/jaundice			
Bleeding tendency/hemophilia/sickle cell			
Breast cancer/biopsy/fibrocystic disease			
HIV infection/AIDS/immunosuppresant med			
Mental illness/suicidal thoughts			
Depression/anxiety disorder			
Kidney problems/failure/dialysis/kid stones			
Hypothyroid/thyroid surgery/parathyroid			
Endometriosis/pelvic infection/uterine fibroids			
Blindness/cataracts/glaucoma/eyeglasses			
Leg pain/foot ulcers/blood clots/poor circulation			
Arthritis/osteoporosis			
Back pain or injury/back surgery/herniated disc			
Prostate enlargement/testicle problems			
Stomach ulcers/vomiting blood			
Diverticulitis/irritable bowel/hemorrhoids			
Crohn's disease/ulcerative colitis			
Esophageal reflux/ulcer/varices/Barret's			
Recent unintentional weight gain/loss			

IF FURTHER INFORMATION IS NEEDED I GIVE MY CONSENT TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY TO RELEASE ANY INFO. I WILL NOTIFY THE DOCTOR OF ANY CHANGES IN MEDICATIONS OR MY HEALTH

Signature: ____

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Reflux (heartburn)

_______Previous history of reflux   Episodes: per week______ per day_____ per night_____

_______Asthma   _______Hoarseness   _______frequent dry cough

_______Difficulty swallowing   _______Food gets stuck   _______vomit acid/bile at night

Previous medications for reflux/heartburn________________________ How long______________

Asthma

Onset as a child __ as an adult __

Hospitalized Y/N   ICU Y/N

Steroids IV __   Oral __   Inhaler __

Albuterol __   Atrovent __   disk __

Sleep Apnea

_______Snore   _______Wake choking   _______Wake with headache

_______Wake frequently   _______Fall asleep reading   _______Fall asleep driving

_______Nap during the day   _______Partner notices you hold your breath while sleeping

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DATE: ________________ SOCIAL SECURITY #: _____________________
NAME: ______________________________________ DOB: __________________
ADDRESS: ___________________________________ APT#: __________________
CITY/STATE: ________________________________ ZIP: ___________________
PHONE #: ________________________ AGE: _______ SEX: M F
EMAIL: _____________________________________ CELL: _________________
YOUR EMPLOYER: ____
OCCUPATION: ________________________________ PHONE: ________________
MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

SPOUSE: ___________________________ SOCIAL SECURITY: _________________
SPOUSE'S EMPLOYER: ___________________________ DOB: ____________
OCCUPATION: ________________________________ PHONE: ________________

EMERGENCY CONTACT NOT LIVING WITH YOU: __________________________
EMERGENCY CONTACT PHONE #: _______________________________________
REFERRED BY: ____________________________ PHONE: ________________
PCP: ___________________________________ PHONE: ________________

HEALTH INSURANCE: ____
POLICY #: _____________________________ GROUP#: ________________
EMPLOYER: _______________________________ PHONE: ________________
SECONDARY INSURANCE: ____
POLICY #: _____________________________ GROUP #: _______________
EMPLOYER: _________________________________ PHONE: ________________

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite health insurance carrier payments. However, the patient will be responsible for all fees, regardless of insurance coverage. Disability forms will be completed for a fee of $10.00.

INSURANCE AUTHORIZATION/ASSIGNMENT

I request that payment of authorized medical and other insurance benefits be paid to Glenn M. Ihde, M.D., P.A. and or Minimally Invasive Bariatrics, PA for any service furnished to me by that party who accepts assignment/physician. I authorize any holder of medical information about me to release to the SSA and HCFA or its intermediaries or carrier or any other insurance company any information needed for this or related Medicare/other insurance claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay a claim.

SIGNATURE: ______________________________________ DATE: ____________

Glenn M. Ihde, MD, PA   Ihde Surgical Group PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

Financial Responsibility Agreement

Patient Name: ____________________________	Date of Birth: ____________	Date of Visit: ______

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, preventative exam, or physical, lab testing, x-ray, EKG, and any other Screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service of Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amount, usual and customary limit or any other type of benefit limitation for the service I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in –network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: ________________________________ **Date**: ____________

Responsible Party Name: ______________________________________

Glenn M. Ihde, MD, PA   Ihde Surgical Group PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

In our efforts to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave messages on a voice mail at home &/or work? Yes No N/A

May we discuss your appointments/treatment with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your appointments and /or treatment with your children? Yes No N/A

You must inform us, in writing, of any changes in your directives. This record takes effect April 14, 2003, and will be kept in your file along with your acknowledgement of receipt of our Notice of Privacy Practices.

Signature: ____________________________________ Date: ___________________

Printed Name: ________________________________ Date of Birth:____________

Witness: _____________________________________ Date: ___________________

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
515 W. Mayfield Road, Suite 402
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817-467-3000
817-467-3001 Fax

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PRIVACY PRACTICE ACT

In our efforts to comply with the Health Information Privacy Practice Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

PLEASE ANSWER THE FOLLOWING QUESTIONS

Please list ***one*** person of your choice who we may speak with regarding your surgery ***postoperatively.***

NAME: ____

ADDRESS: ____________________________ CITY: _________________

STATE: _____________ ZIP: ___________________

PHONE #: __________________ SS#: ___________________

DATE OF BIRTH: ____________________

Please list a password that only you and the person listed above would know. This password would need to be given to Dr. Ihde before any information will be released.

____

Thank you for your assistance in protecting your patient privacy