



23401 Prairie Star Parkway, Suite B300, Lenexa, Kansas 66227 Phone: (913) 677-6319 Fax: (913) 677-1540

# Patient Demographics

**Last Name First Name Middle Initial**

 \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_ □ Male □ Female

**Date of Birth Social Security Number**

**Address Apt./Unit**

**City State Zip Code**

**Primary Phone Secondary Phone**

**Email Address**

**\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age Height Weight Neck Circumference**

**Marital Status**: □ Married □ Single □ Separated □ Divorced □ Widowed □ Undisclosed **Ethnicity**: □ Caucasian □ African American □ Native American □ Asian □ Hispanic □ Pacific Islander / Hawaiian **Employment**: □ Employed/Self Employed □Domestic Engineer □Student □ Retired □Disabled □Unemployed

**Employer Occupation**

**Do you have health insurance?** □ Yes □ No **Have you had a previous bariatric surgery?** □ Yes □ No

**How did you hear about KC Bariatric?**

□ Web Search □Facebook □Instagram □Physician □Friend/Family □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent to Release & Authorize Insurance Information

**Primary Insurance**

**PRIMARY** Insurance Company Policy Subscriber’s Full Name □ Patient is Primary Subscriber

Policy Number Group Number

Subscriber’s Social Security Number Subscriber’s Birth Date Subscriber’s Employer

**Relationship:** □ Self □ Spouse □ Child □ Other:

Customer Service Phone Number

**\* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* Secondary Insurance**

**SECONDARY** Insurance Company Policy Subscriber’s Full Name □ Patient is Primary Subscriber

Policy Number Group Number

Subscriber’s Social Security Number Subscriber’s Birth Date Subscriber’s Employer

**Relationship:** □ Self □ Spouse □ Child □ Other:

Customer Service Phone Number

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*Please include a clear* copy of the front & back of tertiary insurance card, if applicable

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I authorize the office of KC Bariatric, LLC and all associated providers to release my personal and confidential information to my health insurance carrier for the purpose of verifying my coverage, benefits, payment information and researching coverage criteria and/or requirements.

**Patient or Authorized Representative Signature Patient** (and Authorized Representative) **Name Printed**

**Patient’s Date of Birth Today’s Date**

# Privacy Release Authorization

I, , hereby give permission for KC Bariatric, LLC providers and office staff to discuss my **medical condition and care** and/or **billing information** with the following person(s):

**Name Relationship Phone Number**

**□** *Authorized to discuss MEDICAL CONDITION AND CARE* **□** *Authorized to discuss BILLING INFORMATION*

**\* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \***

I, , hereby give permission for KC Bariatric, LLC providers and office staff to contact me at my listed phone number(s) and authorize the following (initial all that apply):

□ You have my permission to identify your office when calling my □ **HOME** □ **CELL** □ **WORK** phone number(s) and to

leave an abbreviated message on my voicemail or with a person identified above. (INITIAL HERE)

□ You have my permission to identify your office when calling my **WORK PHONE NUMBER** and leave the caller’s name

and phone number on my □ **WORK VOICEMAIL** ( and / or ) □ **WITH A CO-WORKER**. (INITIAL HERE)

□ **DO NOT** leave a message indicating any other information besides □ **PHYSICIAN’S NAME** □ **PRACTICE NAME** and

CALLER’S NAME AND RETURN PHONE NUMBER ONLY. (INITIAL HERE)

□ **DO NOT LEAVE ANY KIND OF MESSAGE AT ALL**. (INITIAL HERE)

**Patient’s Date of Birth Today’s Date**

# Current Medical Care & History

**Primary Care Physician Name: \_\_\_\_\_ Years of Care:**

**City: State:**

**Office Phone: Office Fax:**

**Pharmacy Name: Pharmacy Phone: Location:**

**Current Prescription Medication List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Frequency** | **Purpose** | **Date Started** |
|  |  |  |  |  |
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**Current Non-Prescription Medication List**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vitamin / Mineral / Item Name** | **Dose** | **Frequency** | **Purpose** | **Date Started** |
|  |  |  |  |  |
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|  |  |  |  |  |
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**Medication & Substance Allergies**

|  |  |
| --- | --- |
| **Allergic Substance Name** | **Reaction to Substance** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| □ No Known Drug Allergies (NKDA) | □ Latex Allergy |

**Patient Name: Date of Birth:**

# Medical History for Bariatric Surgery

**Past Medical History Assessment**

*Please answer all questions about your current and/or past history. Mark an “X” beside Yes or No for* ***every*** *question.*

|  |  |  |  |
| --- | --- | --- | --- |
| **CARDIOVASCULAR** | **YES** | **NO** | **Physician Notes** ( For Office Use Only ) |
| High Blood Pressure |   |   |   |
| Congestive Heart Failure |   |   |   |
| Ischemic Heart Disease |   |   |   |
| Heart stress test |   |   |   |
| Heart attack |   |   |   |
| Stents placed in Heart |   |   |   |
| Heart catheterization |   |   |   |
| Angina chest pain |   |   |   |
| Peripheral Vascular Disease |   |   |   |
| Stroke |   |   |   |
| Lower Leg Edema / Swelling |   |   |   |
| Blood clot in leg or lung |   |   |   |
| Vena Cava heart filter |   |   |   |
| **METABOLIC** | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Diabetes Mellitus, Type 1 |   |   |   |
| Diabetes Mellitus, Type 2 |   |   |   |
| Fasting Glucose > 99 mg/dL |   |   |   |
| Oral medication for Diabetes |   |   |   |
| Insulin use |   |   |   |
| Eye / Kidney problems |   |   |   |
| High Cholesterol or Lipids |   |   |   |
| Gout / High Uric Acid levels |   |   |   |
| **PULMONARY** | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Oxygen use at home |   |   |   |
| Pulmonary Hypertension |   |   |   |
| Asthma |   |   |   |
| Inhaler use due to Asthma |   |   |   |
| Obstructive Sleep Apnea |   |   |   |
| PAP use to treat Sleep Apnea |   |   |   |

**Patient Name: Date of Birth:**

**Past Medical History Assessment** *(continued)*

|  |  |  |  |
| --- | --- | --- | --- |
| **GASTROINTESTINAL** | **YES** | **NO** | **Physician Notes** ( For Office Use Only ) |
| Heartburn / Reflux / GERD |   |   |   |
| Heartburn medication use |   |   |   |
| Past anti-reflux surgery |   |   |   |
| Barrett’s Esophagus |   |   |   |
| Crohn’s Disease or Colitis |   |   |   |
| Gallstones |   |   |   |
| Gallbladder removal |   |   |   |
| Abnormal liver tests |   |   |   |
| **MUSCULOSKELETAL** | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Back Pain |   |   |   |
| Back Pain requiring medication |   |   |   |
| Hip / Knee / Ankle pain |   |   |   |
| Joint pain requiring medication |   |   |   |
| Fibromyalgia |   |   |   |
| Joint replacement |   |   |   |
| Back surgery |   |   |   |
| **GENERAL** | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Stress urinary incontinence |   |   |   |
| Sanitary pad use for leakage |   |   |   |
| Pseudo tumor Cerebra |   |   |   |
| Abdominal hernia |   |   |   |
| Hernia repair |   |   |   |
| Cane / Walker use |   |   |   |
| Sores / rash in skin folds |   |   |   |
| Previous weight loss surgery |   |   |   |
| MRSA |   |   |   |
| VRE |   |   |   |
| Lupus / Autoimmune disease |   |   |   |
| **PSYCHOLOGICAL** | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Anxiety |   |   |   |
| Depression |   |   |   |
| Bipolar disease |   |   |   |
| Thoughts of suicide |   |   |   |
| Suicide attempts |   |   |   |
| Psychiatric treatment |   |   |   |
| Psychological counseling |   |   |   |
| Hospitalized for psychological issue(s) |   |   |   |

**Patient Name: Date of Birth:**

**Past Medical History Assessment** (continued)

|  |  |  |  |
| --- | --- | --- | --- |
| **REPRODUCTIVE** ( female ) | **YES** | **NO** | Physician Notes ( For Office Use Only ) |
| Polycystic Ovarian Syndrome |   |   |   |
| Infertility |   |   |   |
| Menstrual irregularities |   |   |   |
| Hysterectomy |   |   |   |

**Physical Exercise Assessment**

**Do you have any physical limitation(s) that make physical exercise difficult or impossible?** □ Yes □ No Sometimes If yes, please explain:

**Do you have difficulty with basic mobility or self-care?** □ Yes □ No **Do you use assistive devices to transport?** □ Yes □ No

**Devices currently used** (check all that apply)**:** □ Cane / Walker □ Wheelchair / Scooter □ Crutches / Brace □ Prosthetic Device □ Oxygen

**History of falls within last 12 months**: □ Yes □ No How did it happen?

**Social Assessment**

**Do you use tobacco products / nicotine?** □ Yes □ No **Have you used tobacco products / nicotine in the past?** □ Yes □ No

**If Yes, type of tobacco / nicotine:** □ Cigarettes / packs per day □ Chewing tobacco □ Smokeless tobacco / vaping **Tobacco Use** ( frequency )**:** □ Rare ( 1-2 times / month ) □ Occasionally ( 3 or less / week )□ Frequently ( 4+ / week or daily )

**Have you quit using tobacco products / nicotine?** □ Yes □ No **If yes, what / when was your quit date?**

**Do you use alcohol?** □ Yes □ No **If yes, what type?**

**Alcohol Use** ( frequency )**:** □ Rare ( 1-2 times / month ) □ Occasionally ( 3 or less / week ) □ Frequently ( 4+ / week or daily ) **Do you recreationally use drugs / medication(s) / substance(s)?** □ Yes □ No

**Have you used in the past?** □ Yes □ No **If yes, what type?**

**Recreational Drug Use** ( frequency )**:** □ Rare ( 1-2 times / month ) □ Occasionally ( 3 or less / week ) □ Frequently ( 4+ / week or daily )

**Have you quit using recreational drug(s)?** □ Yes □ No **If yes, what / when was your quit date?**

**Past Surgical History**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURGERY** | **METHOD**( Note if done laparoscopically ) | **DATE** | **PHYSICIAN / LOCATION** |
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**Please list ANY OTHER medical problem(s) / surgical procedure(s) not listed in the Past Medical History Assessment:**

**Family Medical History Assessment**

*Please mark any condition(s) that have been diagnosed in biological relation(s) such as parents, grandparents, siblings. Please check all that apply:*

|  |  |  |  |
| --- | --- | --- | --- |
| □ High Blood Pressure | □ Stroke | □ Heart Disease / Heart Attack | □ Obesity |
| □ Bleeding Disorder | □ Cancer | □ Clotting Disorder | □ Diabetes |

**Sleep Testing Assessment**

Please check any symptom and/or conditions that you experience or that have been noted by a bed partner/spouse or anyone who has witnessed your sleep.

|  |  |  |
| --- | --- | --- |
| * Restless Sleep
* Non-Restorative Sleep
* Fragmented Sleep
* Fatigue
* Hypertension
 | * Snoring
* Gasp/Choke for Breath
* Morning Headaches
* Frequent Night Time Urination
* Cardiac Issues
 | * Excessive Daytime Sleepiness
* Witnessed Apnea
* Depression/Anxiety
* Bruxism(grinding of teeth)
 |

* I have not experienced any symptoms mentioned above.

**STOP BANG Assessment**

Do you snore loudly enough to be heard through closed doors? Yes No Is your BMI greater than 35? Yes No

Do you feel sleepy, fatigued, or fall asleep easily during daytime? Yes No Are you over 50 years old? Yes No

Has anyone observed you stop breathing during sleep? Yes No Is your neck over 16 inches? Yes No

Do you have or are being treated for high blood pressure? Yes No Are you male? Yes No

SBA Score: \_\_\_\_\_\_\_\_\_\_\_ (total number of YES responses to section above)

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep during the following situations?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sitting and Reading: | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| Watching Television: | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| Sitting Inactive in a Public Place (eg. theater) | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| As a Passenger in a Car for an Hour | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| Lying Down to Rest in the Afternoon | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| Sitting and Talking Quietly with Someone | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| Sitting Quietly After a Lunch without Alcohol | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |
| In a Car Stopped for a few Minutes in Traffic | * None (0)
 | * Slight (1)
 | * Moderate (2)
 | * High (3)
 |

ESS Score: \_\_\_\_\_\_\_\_\_\_ (total of answers from responses above)

**Sleep Study & Obstructive Sleep Apnea History**

Have you had a previous sleep study? Yes No If yes, approx. when & where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a prior diagnosis of Sleep Apnea? Yes No Do you currently use PAP therapy? Yes No

If yes, which type? CPAP BiPAP AutoPAP Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Sleep Medicine Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAP Therapy & Supplies Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_