Southwest Florida Metabolic and Bariatric Surgery
Venice Metabolic and Bariatric Surgery
Central Florida Metabolic and Bariatric Surgery
Joseph E Chebli MD FACS

New Patient Registration Form

Patient Name: (first) _____ (last) _____ (m.i) _____

Preferred Name: _____

Address: _____ **Apt #:** _____

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

Email Address: _____

Primary Phone Number: (_____) _____ - _____ **Alternate Phone Number:** (_____) _____ - _____
[ ] Cell **[ ]** Home **[ ]** Work **[ ]** Cell **[ ]** Home **[ ]** Work

Date of Birth: _____ /_____/ _____ **Age:** _____

Sex: **[ ]** Male **[ ]** Female **Social Security Number:** _____

Marital Status: **[ ]** Single **[ ]** Companion **[ ]** Married **[ ]** Divorced **[ ]** Widowed

Patient Emergency Contact: (first) _____ (last) _____

Contact Number: (_____) _____ - _____ **Relation to Patient:** _____

Employment Status: **[ ]** Full-Time **[ ]** Part-Time **[ ]** Unemployed **[ ]** Student **[ ]** Retired **[ ]** Other: _____

Patient Employer: _____ **Occupation:** _____

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Polish
- ☐ American Sign Language
- ☐ Other: _____

Race:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Hispanic / Latino
- ☐ Caucasian
- ☐ Prefer not to disclose

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Prefer not to disclose

INSURANCE INFORMATION:

Who is to be billed for today's visit?

[ ] *Insurance* **[ ]** *Self*

Primary Insurance Provider:	**Secondary Insurance Provider:**
_____	_____
Policy Number: _____	**Policy Number:** _____
Group Number: _____	**Group Number:** _____
Patient is Subscriber/Policy Holder: [ ] Yes **[ ]** No	**Patient is Subscriber/Policy Holder: [ ]** Yes **[ ]** No

Subscriber Information (if other than patient) – *we will request to scan your ID and insurance card(s)*

Policy Holder Name: _____ **Relation to Patient:** _____

Address: _____

Date of Birth: _____ **Social Security Number:** _____

Employer: _____ **Employer Contact Number:** _____

RELEASE OF INFORMATION

It is our responsibility to protect your medical records. We do not release any information regarding you or your medical conditions without your written consent. Please list below whom we can discuss your medical conditions, billing matters, and/or appointment schedule with.

Name:	**Contact Number:**	**Relationship to Patient:**	**Can Discuss:**
_____	(____) _____-_____	_____	☐ Medical ☐ Billing
Name:	**Contact Number:**	**Relationship to Patient:**	**Can Discuss:**
_____	(____) _____-_____	_____	☐ Medical ☐ Billing
Name:	**Contact Number:**	**Relationship to Patient:**	**Can Discuss:**
_____	(____) _____-_____	_____	☐ Medical ☐ Billing

Please mark which number we may call to leave messages. We often contact our patients for the reasons listed below:

To confirm appointments:	☐ Home ☐ Cell ☐ Do not call / leave messages for this
To report lab results / imaging studies:	☐ Home ☐ Cell ☐ Mail to home address ☐ Do not call / leave messages for this

INITIAL EVALUATION FORM

The following information is very important to the care of your health. Please take time to completely fill out this information to the best of your understanding.

Height: _____ Weight: _____ Sex: _____ Age: _____

How did you hear about our practice?

_____

What is your primary reason for making a bariatric consultation?

_____

Are you seeking consultation of weight loss surgery for morbid obesity? _____

At what age did you develop a significant weight problem? _____

Are there events that are contributory to your weight gain? If so, please explain: _____

_____

Have you ever received treatment to lose weight? [ ] YES [ ] NO
If yes, please list what type:

- ☐ Appetite Control Medications _____
- ☐ Restricted / Special Diet _____
- ☐ Surgery / Procedure _____
- ☐ Other _____

Record major diets that resulted in weight loss of 10lbs or more:

Year Started	Length of Diet	Type of Program	Starting Weight	Pounds Lost	How long did the weight stay off?

Patient Care Team

1. **Primary Care Physician:** _____
   Address: _____
   Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
2. **Physician Name:** _____ **Specialty:** _____
   Address: _____
   Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
3. **Physician Name:** _____ **Specialty:**_____
   Address: _____
   Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Pharmacy

1. Name of Pharmacy:

   _____

   Address: _____ [ ] Mail Order Pharmacy

   Phone Number: (____) _____ - _____ Fax Number: (____) _____- _____

2. Name of Pharmacy:

   _____

   Address: _____ [ ] Mail Order Pharmacy

   Phone Number: (____) _____ - _____ Fax Number: (____) _____- _____

Allergies & Medications

Please list any known allergies and their corresponding reactions:

Agent / Medication	Reaction

Please list all prescribed and OTC medications, vitamins, and/or minerals that you are currently using:

Medication	Dose	Times per Day	Year Started	Purpose

Previous Diagnostic Procedures

Please check any of the following diagnostic procedures that have been performed in *the last year* and indicate where we can retrieve them.

- ☐ EKG _____
- ☐ Stress Test _____
- ☐ Chest X-Ray _____
- ☐ Abdominal Ultrasound _____
- ☐ Echocardiogram _____
- ☐ Heart Cath _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Colonoscopy _____
- ☐ CT Scan _____
- ☐ Pulmonary Function Test _____
- ☐ Sleep Study _____
- ☐ Other _____

Surgical History

Have you or a relative ever had bariatric surgery? [ ] YES [ ] NO

If yes, who? _____ Relationship :_____

If yes, what procedure? _____

If yes, by which surgeon? _____

Please list any surgical procedures you have had. Include the year performed and the reason(s) for the procedure(s). Please specify if the procedure was performed *laparoscopic* or *open*.

Surgery	Reason	Year	Laparoscopic / Open

MEDICAL HEALTH INFORMATION

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who is currently managing the diagnosis.

CARDIAC

Coronary Artery Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

MI (Heart Attack) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Elevated Cholesterol ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Chest Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Congestive Heart Failure ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Valvular Heart Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Rheumatic Fever ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Heart Murmur ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Heart Arrythmia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

High Blood Pressure / Hypertension ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PULMONARY

Asthma ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pneumonia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Bronchitis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

COPD (Emphysema) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Tuberculosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Diagnosed Sleep Apnea ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Obesity Hypoventilation Syndrome ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pulmonary Hypertension ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

ENDOCRINE

Diabetes Mellitus ☐ **Yes** ☐ **No**

If yes, how is your Diabetes managed?

- ☐ Insulin
- ☐ Oral medication
- ☐ Combination of both
- ☐ Neither

Year Diagnosed: _____ Physician: _____

Hyperthyroid ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Hypothyroid ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Adrenal (Cushing's) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

GASTROINTESTINAL

Reflux Disease (Heartburn) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Peptic Ulcer Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Gallbladder Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Liver Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Inflammatory Bowel Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Hiatal Hernia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Irritable Bowel Syndrome ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

CANCER

☐ **Yes** ☐ **No**

Type / Organ Affected:

_____

Year Diagnosed: _____ Physician: _____

RENAL

Kidney Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Urinary Stress Incontinence ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Kidney Stones ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PERIPHERAL VASCULAR DISEASE

Arterial Vascular Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pulmonary Embolism ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

DVT (Phlebitis) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Superficial Phlebitis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Peripheral Edema (swelling of legs/ankles) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Leg Ulcers ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Varicose Veins ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

CENTRAL NERVOUS SYSTEM

Stroke ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Seizure ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Cerebral Aneurysm ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Arteriovenous Malformation ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pseudo Tumor Cerebri ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Multiple Sclerosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PSYCHIATRIC DISORDERS

Bipolar Depression ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Anxiety ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Schizophrenia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Eating Disorder ☐ **Yes** ☐ **No**

Type: _____ Year Diagnosed: _____ Physician: _____

Are you receiving therapy or medications? ☐ **Yes** ☐ **No**

Depression ☐ **Yes** ☐ **No**

Severity: ☐ Mild, no treatment ☐ Moderate, with treatment ☐ Severe, with intensive treatment ☐ Severe, requiring hospitalization

Year Diagnosed: _____ Physician: _____

MUSCULOSKELETAL DISORDERS

Gout ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Fibromyalgia ☐ **Yes** ☐ **No**

Treatment: ☐ exercise ☐ Narcotic Medications ☐ Non-Narcotic Medications ☐ No Symptoms

Year Diagnosed: _____ Physician: _____

Abdominal Skin / Pannus ☐ **Yes** ☐ **No**

Symptoms: ☐ Irritation ☐ Interferes with Ambulation ☐ Recurrent Cellulitis and Ulceration ☐ No Symptoms

Year Diagnosed: _____ Physician:_____

Functional Status Limited ☐ **Yes** ☐ **No**

☐ Requires Wheelchair ☐ Able to walk 200ft with cane / crutch ☐ Unable to walk 200ft without cane / crutch

Lower Back Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Osteoarthritis / DJD ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Osteoporosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Joint Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Autoimmune Disease ☐ **Yes** ☐ **No**

Explain Further:
(Ex: Lupus, Rheumatoid Arthritis, Connective Tissue, etc.) _____

_____

Year Diagnosed: _____ Physician: _____

OBSTETRICAL/GYNECOLOGICAL

Menstrual Irregularities ☐ **Yes** ☐ **No**
Explain: _____

Polycystic Ovarian Syndrome ☐ **Yes** ☐ **No**
Year Diagnosed: _____ Physician: _____

History of Breast Cancer ☐ **Yes** ☐ **No**
Year Diagnosed: _____ Physician: _____

Indicate if you are ☐ **Pre-Menopausal** ☐ **Post-Menopausal**

Hysterectomy ☐ **Yes** ☐ **No** Year: _____
How was it performed? ☐ **Vaginal** ☐ **Abdominal**
Were Ovaries removed? ☐ **Yes** ☐ **No**

Tubal Ligation ☐ **Yes** ☐ **No** Year: _____
How was it performed? ☐ **Open** ☐ **Laparoscopic**

Number of Pregnancies to term: _____

Number of deliveries: _____

SOCIAL HISTORY

Occupation: _____

☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Disabled**
Please indicate cause: _____

What category best describes your highest level of education?

☐ **High school** ☐ **College** ☐ **Graduate School** ☐ **Vocational** ☐ **Other**

What is your religious affiliation?

☐ **Atheist** ☐ **Christian** ☐ **Catholic** ☐ **Jehovah Witness** ☐ **Jewish** ☐ **Other**

Do you have any children? ☐ **Yes** ☐ **No**
If yes, how many? _____

What are their names and ages?

_____ _____
_____ _____
_____ _____
_____ _____

TOBACCO / NICOTINE HISTORY

Do you currently use tobacco or nicotine products? ☐ **Yes** ☐ **No**

Have you ever used tobacco or nicotine products? ☐ **Yes** ☐ **No**

What type?

☐ **Cigarettes** ☐ **Vapor** ☐ **Chew / Snuff** ☐ **Cigar**

How many per day? _____

Start Age: _____ **Stop Age:** _____ **Total years used:** _____

DRUG HISTORY

Have you ever used illicit drugs? ☐ **Yes** ☐ **No**

What type?

☐ **Marijuana** ☐ **Cocaine** ☐ **Heroin** ☐ **Amphetamine**

How long ago?

☐ **Less than 5 months** ☐ **6 months – 1 year** ☐ **Over 1 year**

ALCOHOL HISTORY

Do you currently drink alcohol? ☐ **Yes** ☐ **No**

What type?

☐ **Wine** ☐ **Beer** ☐ **Liquor** ☐ **Mixed**

How many drinks do you currently consume?

Daily: _____ **Weekly:** _____ **Monthly:** _____ **Yearly:** _____

Have you ever had a problem with alcohol abuse in the past? ☐ **Yes** ☐ **No**

Indicate how long: _____ Treatment: _____

What type did you drink?

☐ **Wine** ☐ **Beer** ☐ **Liquor** ☐ **Mixed**

FAMILY HISTORY

In this section please complete this chart to the best of your knowledge.

Has anyone in your family ever had a blood clot in their legs or lungs? ☐ **Yes** ☐ **No**

Has anyone in your family ever had a stroke? ☐ **Yes** ☐ **No**

Family Member	**Deceased**	**Present Age**	**Medical Problems**
FATHER	☐		
MOTHER	☐		
PATERNAL GRANDFATHER	☐		
PATERNAL GRANDMOTHER	☐		
MATERNAL GRANDFATHER	☐		
MATERNAL GRANDMOTHER	☐		
SIBLINGS	☐		
	☐		
CHILDREN	☐		
	☐		

QUESTIONS & CONCERNS

Please share any specific questions or concerns that you may have, to ensure that our team can address them at your consultation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I *(patient printed name)* , _____ hereby declare that the details furnished in this document are true and correct to the best of my knowledge and belief, and I undertake responsibility to inform you of any changes therein, immediately.

_____ _____

(Patient Signature) *(Date)*

FINANCIAL POLICY FOR SURGERY

It is important for you to understand your financial obligations associated with your surgery. Please review the following and sign to indicate your understanding and acceptance of this responsibility.

1. Payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of services, your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and posted to your account, you will then receive a statement for any outstanding portion of the account (deductible).
3. *We appreciate payment in full within 10 days*. If payment cannot be made in full within 30 days of the first statement, you will be directed to our billing office to set up a payment plan. A payment plan may be established using:
    a. Payments with a credit card.
    b. Line of credit through a medical services credit company.
    c. Establishing a monthly payment contract with our office.
4. Statements will be made monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement, then the account may be forwarded to collections in accordance with the laws established by the state of Florida.
5. **Prior to elective surgery, we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. Payment of this balance is required at the pre-operative appointment.**
6. Any questions or concerns regarding billing is to be addressed directly with the billing staff and *not* your surgeon.

I am signing this document of my own free will. I understand my responsibilities for payment of the surgery, all related care, and costs associated with the surgery.

_____ _____

(Patient Signature) *(Date)*

BARIATRIC PATIENT WEBSITE ACKNOWLEDGEMENT

I, *(patient printed name)* _____ , acknowledge that I have reviewed the practice website: ***www.sfmbs.com***.

I have read detailed explanations on:

- ✓ Morbid Obesity
- ✓ Surgical Options for Treatment
- ✓ Benefits and Risks of Obesity Surgery
- ✓ Expected Weight Loss
- ✓ Surgical Techniques and Videos

_____ _____

(Patient Signature) *(Date)*

Southwest Florida Metabolic and Bariatric Surgery
Authorization for Release of Information

_____ _____

Patient Name *Date of Birth*

Please send information to:

Joseph E. Chebli, MD, FACS

1370 E. Venice Avenue. Suite # 208

Venice, FL. 34285

Phone: (941) 209 – 4646

Fax: (941) 445 – 4152

Information to be released:

☐ All medical records

☐ Specific information (Please specify)

_____

_____

_____

Purpose for which disclosure is being made: Continuity of care

Patient Authorization:

I understand that my records may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give specific authorization for these records to be released.

Exclude the following information from the records to be released:

☐ Drug/Alcohol abuse, treatment, and diagnosis.

☐ Sexually transmitted disease

☐ HIV / AIDS diagnosis, treatment, and testing.

☐ Mental illness / psychiatric treatment.

My Rights:

I understand that I do not have to sign this authorization to obtain health care benefits, treatment, payment, or enrollment. I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person(s) or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

This authorization will expire 1 year from the date signed.

_____ _____

(Patient Signature) *(Date)*