Patient Name:

WILJON W. BELTRE, M.D., F.A.C.S.

CENTER FOR METABOLIC and OBESITY SURGERY

Today's Date: _____/_____/_____ _____-____-_____
Month Day Year Social Security Number

Name: _____ _____ _____ _____
Last First MI Maiden Name

Address: _____
Street

_____

_____ _____ _____ _____
City State Zip code Country

Telephone: (_____)-_____ -_____ (_)-_____ -_____Email_____
Home Cell

Birthdate _____/_____/_____ Age: _____ Sex: M / F
Month Day Year

Your Race: _____ Asian _____ African American _____Caucasian

_____ Hispanic Other _____

Birthplace: _____

Referred by (circle appropriate option): Self / Family / Friend / Doctor / Other

Name (of person making referral): _____

Primary Health Care Provider: Dr. _____

Referring Dr. Phone No. (_____)_____ -_____
Primary Health Care Dr. Phone No. (_____)_____ -_____

REQUIREMENT FOR INSURANCE CLAIM FILING
I hereby authorize the physician(s) to release any information acquired in the course of my examination and treatment. Furthermore, I authorize payment directly to the physician(s) of the Medical/Surgical benefits otherwise payable to me for services as described. A photostatic copy of the authorization shall be considered as valid as the original, and shall be valid for one year from the date of signature.

_____ _____ _____
SIGNATURE OF PATIENT / INSURED DATE INSURED'S NAME (PLEASE PRINT)

Patients Employer Information:

Company Name: _____

Company Address: _____

_____

_____

Company Phone: _____ _____ - _____

Company Fax: _____ _____- _____

Patient Insurance Information:

Company Name: _____

Company Address: _____

_____

_____

Company Phone: _____ _____- _____

Company Fax: _____ _____- _____

Policy Number: _____

ID Number: _____

Group Number _____

I certify that the above insurance information that I have provided is true and correct.

_____ _____ _____

SIGNATURE OF PATIENT / INSURED DATE INSURED'S NAME (PLEASE PRINT)

Patient Name:

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE SO THAT WE CAN GIVE YOU THE BEST POSSIBLE MEDICAL CARE.

Briefly state your problem or the reason for your coming to the doctor today.

Have you seen any other doctor(s) for this problem?

When did you first notice the current problem?

Describe the location of your pain / discomfort (if appropriate).

Describe your discomfort. (burning, aching, throbbing, pulling, crushing, stabbing, itching, etc.)

Does your pain/discomfort radiate or shoot to any other area of your body?

Can you mark (circle) the severity of your pain/ discomfort on a scale of 0 to 10?

0---------1---------2---------3---------4---------**5**---------6---------7---------8---------9---------**10**
(0 = no pain ----------10 = worst pain ever)

How long has this problem been bothering you?

How often do you experience this problem (every day/week/month)?

Is there anything you can do to make this problem better?

Is there anything you can do that you know will cause this problem or make it worse?

Is this problem related to any other problems or complaints that you are having?

Patient Name:

Past Personal Medical History:

Do you have, or have you had in the past, any of the following (circle Yes or No) ?

Yes / No - Asthma	Yes / No - Pneumonia
Yes / No - Emphysema	Yes / No - Heart Valve Problems
Yes / No - Heart Attack	Yes / No - Heart Rhythm Problems
Yes / No - High Blood Pressure	Yes / No - Stroke
Yes / No - Aneurism	Yes / No - High Cholesterol/Triglycerides
Yes / No - Diabetes	Yes / No - Pancreatitis
Yes / No - Thyroid Problems	Yes / No - Immune system problems
Yes / No - Bad Headaches	Yes / No - Epilepsy
Yes / No - Jaundice	Yes / No - Hepatitis
Yes / No - Stomach Ulcers	Yes / No - Reflux/Heart Burn
Yes / No - Kidney Disease	Yes / No - Cancer
Yes / No - Excessive Bleeding	Yes / No - Anemia
Yes / No - Excessive clotting	Yes/ No - Clots in the leg veins
Yes/No - Sleep Apnea	Yes/No - Pulmonary Embolism
Yes / No - Leukemia	Yes / No - Psychiatric disorders
Yes / No - Colitis	Yes / No - Diverticulitis
Yes / No - Constipation	Yes / No - Small bowel inflammation
Yes/ No - Alcoholism	Yes / No - Drug dependence
Yes / No - Arthritis	Yes / No - Gout

Yes / No -Other significant Illnesses (Please List)_____

_____

_____

_____

Patient Name:

Please list any **PREVIOUS OPERATIONS**:

	Year	Type of operation	Surgeon
1)			
2			
3			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			

HAVE YOU EVER HAD ANY PROBLEMS RELATED TO ANESTHETICS, GENERAL OR LOCAL?

If yes please describe:

Patient Name:

Current Medications:

Please list **all medications** you are currently using.
(Include Aspirin, vitamins, laxatives, contraceptives, herbals and other "over the counter" items)

Name of medicine	Strength (mg)	Number of pills	Times per day
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

Are there any medications that you are **ALLERGIC TO** or not able to take? (circle) Yes / No

	Name of Drug	What happens if you take this drug?
If Yes:	1)	
	2)	
	3)	
	4)	
	5)	
	6)	

Patient Name:

FOR WOMEN ONLY

Menstrual History (for women only):

Age when periods began _____ Date of last period _____/_____/_____

Are your periods regular? Yes / No How many days apart? _____

ARE YOU OR MIGHT YOU POSSIBLY BE PREGNANT? YES _____ NO _____

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____

HOW MANY BABIES HAVE YOU HAD? _____

SOCIAL HISTORY

Your Highest Level of Education:

____ High School ____College ____Post graduate

Marital Status:

___Single ____Separated ___Married ____Divorced

Habits:

Do you smoke now? Yes/ No If Yes:

How many packs per day? _____ How many years_____

If No: Did you smoke in the past? Yes / No

How many packs per day? _____ How many years? _____ Year you quit? _____

Do you drink alcohol now? Yes / No

If yes: How many drinks per day? _____ How many years? _____

If you are married:

Does your **spouse smoke now**? Yes / No

If yes:

How many per day? _____ How many years? _____

If No:

Did they **smoke in the past**? Yes / No

How many per day? _____ How many years? _____ Year they quit? _____

Do you **drink alcohol now**? Yes / No

If yes:

How many per day? _____ How many years? _____

If No:

Did you **drink alcohol in the past**? Yes / No

How many per day? _____ How many years? _____

Patient Name:

Family History:

	If Living		If Deceased	
	Age	Current Health	Age at Death	Cause of death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

	Sex(M/F)	Age	Current Health	Age at Death	Cause of death
Child					
Child					
Child					
Child					
Child					
Child					
Child					

Extended Family History:

Do you know of any blood relatives who have, or have had in the past, any of the following illnesses? **(If Yes, list their relationship to you.)**

Asthma		Heart Problems	
High Blood Pressure		Stroke	
Diabetes		Epilepsy	
Jaundice		Stomach Ulcers	
Kidney Disease		Excessive Bleeding	
Colitis		Alcoholism	
Cancer (type?)		Leukemia	

Patient Name:

System Review (If you have any questions, ask the physician):

General/Constitutional:
Yes / No Fever
Yes / No Fatigue
Yes / No Weakness
Yes / No Recent weight gain (amount _____)
Yes / No Recent weight loss (amount _____)

Eyes:
Yes / No Pain
Yes / No Redness
Yes / No Loss of vision
Yes / No Double or blurred vision
Yes / No Flashing lights/Spots
Yes / No Dryness
Yes / No Feels like something in eye
Yes / No Glasses
Yes / No Other _____

Ears, Nose, Mouth, Throat:
Yes / No Ringing in ears
Yes / No Loss of hearing
Yes / No Nose bleeds
Yes / No Loss of sense of smell
Yes / No Dry sinuses
Yes / No Sinusitis
Yes / No Post-nasal drip
Yes / No Sore tongue
Yes / No Bleeding gums
Yes / No Sores in the mouth
Yes / No Loss of sense of taste
Yes / No Dry mouth
Yes / No Dentures/Removable dental work
Yes / No Frequent sore throats
Yes / No Hoarseness
Yes / No Constantly feel the need to clear your throat when nothing is there
Yes / No Wake up with acid or bitter fluid in the mouth or throat
Yes / No Food sticks in the throat when swallowing
Yes / No Painful swallowing
Yes / No Other _____

Cardiovascular:
Yes / No Chest pain
Yes / No Irregular heart beat
Yes / No Sudden changes in heart beat (palpitations)
Yes / No Shortness of breath
Yes / No Difficulty in breathing at night
Yes / No Swollen legs or feet
Yes / No Heart murmurs
Yes / No High blood pressure
Yes / No Cramping with walking
Yes / No Pain in feet or toes at night
Yes / No Varicose veins
Yes / No Other _____

Respiratory:
Yes / No Chronic dry cough
Yes / No Coughing up blood
Yes / No Coughing up mucous
Yes / No Wake up at night coughing or choking
Yes / No Repeated pneumonias
Yes / No Wheezing
Yes / No Night sweats
Yes / No Other _____

Gastrointestinal:
Yes / No Decreased appetite
Yes / No Nausea
Yes / No Vomiting
Yes / No Vomiting blood or coffee ground material
Yes / No Heartburn
Yes / No Regurgitation
Yes / No Frequent belching
Yes / No Stomach pain relieved by food
Yes / No Yellow Jaundice
Yes / No Diarrhea
Yes / No Constipation
Yes / No Gas
Yes / No Blood in stools
Yes / No Black, tarry stools
Yes / No Hemorrhoids
Yes / No Other _____

Genitourinary:
Yes / No Difficult urination
Yes / No Pain or burning with urination
Yes / No Blood in the urine
Yes / No Cloudy or "smoky" urine
Yes / No Frequent need to urinate
Yes / No Urgency
Yes / No Needing to urinate frequently at night
Yes / No Not able to hold your urine
Yes / No Discharge from the penis/vagina
Yes / No Kidney stones
Yes / No Vaginal dryness
Yes / No Rash or ulcers
Yes / No Sexual difficulties
Yes / No Impotence
Yes / No Prostate trouble
Yes / No Sexually transmitted diseases

Musculoskeletal:
Yes / No Arm cramps
Yes / No Buttock cramps
Yes / No Thigh cramps

Yes / No Calf cramps
Yes / No Joint/muscle pain
Yes / No Muscle weakness
Yes / No Muscle tenderness
Yes / No Joint swelling
Yes / No Neck pain
Yes / No Back pain
Yes / No Injuries
Yes / No Other _____

Skin and Breasts:
Yes / No Easy bruising
Yes / No Skin redness
Yes / No Skin rash
Yes / No Hives
Yes / No Sensitivity to sun exposure
Yes / No Tightness
Yes / No Nodules/bumps
Yes / No Hair loss
Yes / No Color changes in the hands or feet in the cold
Yes / No Breast lump
Yes / No Breast pain
Yes / No Nipple discharge
Yes / No Other _____

Neurological:
Yes / No Headache
Yes / No Dizziness

Yes / No Fainting
Yes / No Muscle spasms
Yes / No Loss of consciousness
Yes / No Sensitivity or pain of hands and/or feet
Yes / No Memory loss
Yes / No Other _____

Psychiatric:
Yes / No Depression with thoughts of suicide
Yes / No Voices in your head telling you to do things
Yes / No Been seen professionally for psychiatric counseling / treatment
Yes / No Other _____

Endocrine:
Yes / No Can't tolerate hot or cold temperatures
Yes / No Flushing
Yes / No Finger nail changes
Yes / No Increased thirst
Yes / No Increased salt intake
Yes / No Decreased sexual desire
Yes / No Other _____

Hematologic/Lymphatic:
Yes / No Anemia
Yes / No Bleeding tendency
Yes / No Clotting tendency
Yes / No Other _____

Allergic/Immunologic:
Yes / No Rhinitis
Yes / No Asthma
Yes / No Skin sensitivity
Yes / No Latex allergy/sensitivity
Yes / No Other _____

==========

This section is for physician use only. NOT FOR PATIENT SIGNATURE

The Review of Systems section was reviewed with the patient

By Dr.:_____ ____/____/____
Signature Date

_____

Center for Metabolic & Obesity Surgery
Specializing in Minimally Invasive
Weight Loss Surgery & Advance Laparoscopy
Wiljon W. Beltre MD, F.A.C.S

Please note that most health insurances that cover obesity surgery will have you complete a medical weight loss program lasting from four to six months, before they approve the surgery. However, if you have completed a weight loss program in the past two years, they may give you credit and you may not have to wait the time period to get your Surgery approved. Weight Loss programs that you may get credit for include:

1. **Weight Loss program through a doctor, nurse or nutritionist**
2. **Jenny Craig**
3. **Weight Watchers**
4. **Transformations**
5. **Nutra System**

Have you done a supervised weight loss program in the last two years? Yes ____ No ____
Did the weight loss program last for four or more months? Yes ____ No ____
Are you able to get records? Yes ____ No ____
Name of weight loss program or doctor _____

Center for Metabolic & Obesity Surgery
Specializing in Minimally Invasive
Weight Loss Surgery & Advance Laparoscopy
Wiljon W. Beltre MD, F.A.C.S

Notice of Privacy Practice Acknowledgment Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made release on your prior consent.

Patient Name: _____ Date: _____
(Print)
Patient Signature: _____ Witness: _____

Revisions:
Revised date: _____ Patient Received Signature: _____ Date: _____
Revised date: _____ Patient Received Signature: _____ Date: _____
Revised date: _____ Patient Received Signature: _____ Date: _____
Revised date: _____ Patient Received Signature: _____ Date: _____

(Office use only)

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgment form but was unable to do so as documented below:

Reason:
_____
_____
_____
_____

Date: _____
Employee Signature: _____