Date attended class:_____

Ridgeview MEDICAL CENTER
Bariatric & Weight Loss Center

Edmund Chute, MD
Jeffrey Baker, MD

Procedure of choice:

□ Laparoscopic Roux-en-Y Gastric Bypass

□ Sleeve Gastrectomy

□ Adjustable Gastric Band

□ Unsure

Personal Information:

First Name: _____ Middle Initial _____ Last Name_____

Date of Birth: _____ Social Security: _____-_____-_____

Gender: M F Race_____ Marital Status: _____ Spouse's/partner's name: _____

Home Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____@_____

Work Information:

Business Name: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Fax: _____-_____-_____

Email Address: _____@_____

Insurance Information:

Primary Insurance

Company: _____ Subscriber: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____

ID Number: _____ Group Number: _____

Secondary Insurance

Company: _____ Subscriber: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____

ID Number: _____ Group Number: _____

Primary Doctor:

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Fax: _____-_____-_____

How long have you been going to this doctor? _____

Doctor/Specialist:

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Fax: _____-_____-_____

How long have you been going to this doctor? _____

Psychologist/Psychiatrist: (if you are seeing one)

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Fax: _____-_____-_____

How long have you been going to this doctor? _____

Emergency Contact Information: (must list two)

EMERGENCY CONTACT #1: Relationship: _____

First name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Cell: _____-_____-_____

Email Address: _____@_____

EMERGENCY CONTACT #2: Relationship: _____

First name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____-_____-_____ Cell: _____-_____-_____

Email Address: _____@_____

Personal Weight History:

Height: _____feet_____inches Present Weight: _____ (Office use) BMI_____

Age you 1st became overweight: _____ Age you became 100 lbs. overweight: _____

Weight at age 18:_____ Five years ago:_____ Highest weight in five years:_____ Lowest weight in five years:_____

Previous dietary weight loss efforts:

Name of program or Doctor	Start Date (M/Y)	End Date (M/Y)	Starting Weight	Ending Weight
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

Health Information: How is your health in general? ☐ good ☐ fair ☐ poor

Central Nervous System/Psychological:

Have you been depressed? ☐ yes ☐ no

Hospitalized for depression? ☐ yes ☐ no

Have you been suicidal? ☐ yes ☐ no

Are you taking medications for depression? ☐ yes ☐ no

Do you have or have you had any other mental health problems? ☐ yes ☐ no

Please describe. _____

Do you have a history of substance or alcohol abuse? ☐ yes ☐ no

Please describe. _____

Average # alcoholic drinks per week: _____ OR per month: _____

Do you have idiopathic intracranial hypertension (high fluid pressure in the brain)? ☐ yes ☐ no

Cardiovascular:

Do you have hypertension (high blood pressure)? ☐ yes ☐ no

If so, how many years? _____

Do you have heart disease? ☐ yes ☐ no

If so, please describe. _____

Have you taken phen-fen? ☐ yes ☐ no

When? _____ For how long? _____# pounds lost on it _____

Pulmonary:

Do you have lung problems? ☐ yes ☐ no

Please describe. _____

Do you smoke? ☐ yes ☐ no

Have you quit? ☐ yes ☐ no When? _____

Do you have asthma? ☐ yes ☐ no

Do you have sleep apnea? ☐ yes ☐ no

Do you use CPAP (continuous positive airway pressure)? ☐ yes ☐ no

Does your family say you have loud and irregular snoring? ☐ yes ☐ no

What is the chance that you would doze off when you are:

Sitting and reading?	☐never	☐slight	☐moderate	☐high	____
Watching television?	☐never	☐slight	☐moderate	☐high	____
Sitting inactive in a public place, like in a theater or meeting?	☐never	☐slight	☐moderate	☐high	____
A passenger in a car?	☐never	☐slight	☐moderate	☐high	____
Lying down to rest in the afternoon?	☐never	☐slight	☐moderate	☐high	____
Sitting quietly after lunch (when you have not had alcohol)?	☐never	☐slight	☐moderate	☐high	____
In a car, stopped in traffic?	☐never	☐slight	☐moderate	☐high	____
	0	1	2	3	

Office use only: ____/24

Gastrointestinal:

Do you have frequent heartburn? ☐yes ☐no

Do you take antacids or other medication for heartburn? ☐yes ☐no

Do you have gastroesophageal reflux disease (GERD)? ☐yes ☐no

Are you taking medication for GERD? How many years? _____ ☐yes ☐no

Have you had an upper endoscopy (gastroscopy)? ☐yes ☐no

When? _____ Where was it done? _____

Do you have a history of jaundice or hepatitis? ☐yes ☐no

Have you had an ulcer? ☐yes ☐no

Genitourinary:

Do you have kidney problems? ☐yes ☐no

Do you sometimes lose your urine with coughing or sneezing? ☐yes ☐no

If so, how often? _____

Have you been diagnosed with urinary stress incontinence? ☐yes ☐no

Are you infertile? ☐yes ☐no

Have you seen a doctor about this? ☐yes ☐no

If yes, what is the diagnosis? _____ ☐yes ☐no

For women: # of pregnancies _____# of babies _____ When was your last period? _____

Musculoskeletal:

Do you have bone, joint or muscle problems? ☐yes ☐no

Which joints? ☐Spine ☐hips ☐knees ☐ankle ☐other

Is there a diagnosis ☐yes ☐no Diagnosis: _____

Do you have lower leg venous stasis ulcers? ☐yes ☐no

Do you have fibromyalgia? ☐yes ☐no

Hematology/Oncology?

Do you have a history of abnormal bleeding or clotting? ☐yes ☐no

Do you or have you had anemia (low hemoglobin)? ☐yes ☐no

Are you HIV positive? ☐yes ☐no

Ever been MRSA+? ☐yes ☐no

VRE+ ☐yes ☐no

Have you had a cancer or any other tumor? ☐yes ☐no

When? _____ Where was the cancer? _____

Metabolic:

Do you have elevated cholesterol or triglycerides or lipids? ☐yes ☐no

Do you have diabetes mellitus ("sugar diabetes")? When diagnosed? _____ ☐yes ☐no

Do you take pills for this? ☐yes ☐no Do you take insulin for this? ☐yes ☐no

Family History:

Have any of your family members had any of these illnesses? (even if deceased):

Relative	Weight	Diabetes	Heart problems or attack	High blood pressure	Sleep apnea	High cholesterol	Joint problems	Stroke or blood clots
Father								
Mother								
Brother 1								
Brother 2								
Brother 3								
Brother 4								
Sister 1								
Sister 2								
Sister 3								
Sister 4								

Medications: *Please list all medications, including non-prescription medications and supplements.*

Name of Medication/Supplement: Dose: How often do you take it? Purpose of the medication:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Attach additional pages if necessary.

Allergies: *Please list any allergy to foods or medications and the reactions that you have to them.*

Food/Medication: *What was the reaction?* *When did you have a reaction?*

_____

_____

_____

_____

_____

_____

Surgeries: *Please list any previous surgeries that you have had*.

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

Review of Unrelated Medical Systems: *Please mark all that you have now or that you have had in the past:*

- ◯ Excessive fatigue
- ◯ Shortness of breath
- ◯ Frequent urination
- ◯ Wake at night unable to breathe
- ◯ Urgency to urinate
- ◯ Double vision
- ◯ Blood in urine
- ◯ Change in vision
- ◯ Leg/foot swelling
- ◯ Hearing loss
- ◯ Heart attack
- ◯ Prostate problems
- ◯ Fluttering in chest
- ◯ Muscle problems
- ◯ Frequent ear infections
- ◯ Nose bleeds
- ◯ Ear drainage
- ◯ Abnormal heart valve
- ◯ Frequent cough
- ◯ Stroke
- ◯ Muscle weakness
- ◯ Numbness
- ◯ Lumps in nose
- ◯ "Pins & needles" feeling
- ◯ Growths in mouth
- ◯ Sinus infections
- ◯ Excessive urination
- ◯ Pneumonia
- ◯ Emphysema
- ◯ Spinal cord/brain injury
- ◯ Blood clot in lungs
- ◯ Abnormal bleeding
- ◯ Tuberculosis
- ◯ Frequent infections
- ◯ Blood clot in leg
- ◯ Trouble swallowing
- ◯ Lump in neck
- ◯ Trouble speaking
- ◯ Vomiting
- ◯ Constipation
- ◯ Diarrhea
- ◯ Intolerant of cold
- ◯ Lump in breast
- ◯ Pancreas problem
- ◯ Intolerant of heat
- ◯ Gallstones
- ◯ Chest pain
- ◯ Thyroid problem
- ◯ Crohn's disease
- ◯ Blurry vision
- ◯ Can't sleep lying down
- ◯ Kidney stones
- ◯ Ringing in ears
- ◯ Leg cramping
- ◯ Frequent runny nose
- ◯ Muscular dystrophy
- ◯ Phlegm production
- ◯ Seizures
- ◯ Sores in mouth
- ◯ Easy bruising
- ◯ Frequent nausea
- ◯ Stiff neck
- ◯ Blood in stool
- ◯ Abnormal immune system
- ◯ Lump in armpit
- ◯ Lump in groin

Please tell us anything else that you would like us to know to help us provide you with the best possible care.

_____

_____

_____

_____

_____

_____

Authorization to release information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ Date_____

Signature

Authorization to pay benefits to physician: I understand that as a courtesy to me Ridgeview Bariatric & Weight Loss Center will file insurance claims on my behalf. I understand, however, that I am responsible for payment of services that I have received. I hereby authorize payment directly to the physician of the Surgical or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

_____ Date_____

Signature

Medicare patients:

We are participating physicians in the Medicare program and accept assignment of benefits from Medicare, however, you are still responsible for your deductible and co-insurance amounts after Medicare has paid. Your signature below will serve as the authorization for payment from Medicare to Ridgeview Bariatric & Weight Loss Center.

_____ Date_____

Signature

ALL PATIENTS and PROSPECTIVE PATIENTS MUST READ AND SIGN BELOW:

******IMPORTANT******

Although I understand that Ridgeview's Insurance Specialists will call my insurance company on my behalf to verify coverage for Bariatric Surgery, I understand that it is ultimately my responsibility to know whether or not Bariatric Surgery and the Pre and Post Op Required Appointments are a covered benefit.

I will not hold Ridgeview Medical Center, Ridgeview Bariatric and Weight Loss Clinic, its staff or supporting staff responsible for insurance misinformation, insurance changes, coverage changes or plan changes. It is my responsibility to inform Ridgeview Bariatric and Weight Loss Clinic in writing (Mail or Email) of any changes to insurance plans or coverage.

_____ Date_____

Signature

Authorization for Disclosure of Protected Health Information - CLINIC

Print Patient's legal name_____ Previous Names _____

Address, City, State Zip_____Birth date_____/_____/_____

Phone numbers (Home)_____-_____-_____(Work)_____-_____-_____(Other)_____-_____-_____

This form, when completed and signed, authorizes the parties below to release and/or exchange protected information from records.

I authorize: ☐ All RMC Clinics or: ☐ Belle Plaine ☐ Chanhassen ☐ Chaska ☐ Delano ☐ Excelsior ☐ Howard Lake ☐ Le Sueur ☐ Westonka ☐ Winsted ☐ Specialty Clinic _____ ☐ RMC Sibley _____

Clinic Address:_____, MN Zip Code: _____

Fax: _____ or 952-442-6037 Phone: (952) 777-4174

To release ☐ TO or ☐ RECEIVE FROM the following party:

Person, clinic or organization: _____

Address:_____City: _____

State:_____Zip code:_____Phone:_____-_____-_____Fax:_____-_____-_____

To release and/exchange the following information: ☐ Any and all records (includes all types of records listed below):

☐ Progress Notes ☐ Itemized Bills ☐ Lab/Pathology Reports ☐ Consult Reports by Dr. _____

☐ Radiology Films/Images ☐ Radiology Reports ☐ Pre-Employment Records ☐ hospital/medical center reports

☐ Other: _____

For condition or dates of treatment:_____(*If blank, we will release 1 year's worth of most recent records*.)

I would like to receive my records by: ☐ I will pick up ☐ Mail ☐ Email _____

I understand the following:

Except for psychotherapy notes (which are not included in my medical record), all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV will be released. If I don't want these to be released, I will place a checkmark here:_____. I DO NOT want the following records released:

☐ Alcohol/Drug Use or Abuse Records ☐ Mental Health Records ☐ AIDS/HIV Records ☐ Sickle Cell ☐ Genetic Conditions

Purpose of Disclosure:

☐ Continued care by another provider ☐ Insurance claim ☐ Personal use ☐ Transfer of Care ☐ Moving

☐ Coordination of Services ☐ Legal ☐ Other _____

If releasing records to yourself, should the envelope be marked "Personal and Confidential"? ☐Yes ☐No

This form expires one year after I sign it or sooner (specify here:_____). The time period noted here may exceed one year in certain situations specified by law.

I understand that I may revoke this authorization at any time by sending written notice to the health facilities noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. Once the records are released, Ridgeview Medical Center cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.

I hereby authorize the above facilities to disclose medical information concerning the above named patient. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, also HIV related information. I understand that once information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits.

X X

Date **Signature of client or authorized person** **Authorized person's authority to sign**

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other: _____

To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.

Office Use: ☐ Mailed ☐ Faxed ☐ Patient Pickup ☐ Email | ☐ Identification Verified Initials_____Date: _____