Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

PATIENT INFORMATION: **TODAY'S DATE____________**

Last Name: ____ First Name: _______________________________________ Middle Initial:___________

Date of Birth: ________________ Sex: ____Male ____Female SS#:___________________________ Marital Status:__________________________

Street Address: ______________________________________ City: _______________________ State: _____________ Zip Code: _______________

Home Phone: ___________________________ Work Phone: ___________________________ Mobile Phone: _______________________________

Email: _________________________________ Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

AUTHORIZATION: I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

Referring Provider: __________________________________ Patient PCP: __________________________________

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other ______________________

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other _________________________)

GUARDIAN INFORMATION:

Guardian Last Name: _________________________________ Guardian First Name: ___________________________ M. Name:______________

EMERGENCY CONTACT INFORMATION:

Last Name:_________________________ First Name:________________________ Phone:________________ Relationship:_____________________

INSURANCE INFORMATION: *Please bring insurance card(s) to the visit*

Insurance Plan Name: __________________________________ Policy Holder Name: ______________________ Policy Holder DOB: _______________

EMPLOYER INFORMATION:

Employer Name: ____________________________________ Employer Phone: _____________________________ Occupation:______________

CLINICAL INFORMATION:

Preferred Pharmacy: ____Phone: _____________________ Fax: ____________________

Preferred Laboratory: ____

Protected Health Information Authorization:

Please list any family members or others who may be involved in coordinating your care. Also, indicate what kinds of information may be shared with each individual.

Name	**Relationship to Patient**	**Type of information** All	Schedule	Medical	Billing
________________________	________________________________	Y/N	Y/N	Y/N	Y/N
________________________	________________________________	Y/N	Y/N	Y/N	Y/N
________________________	________________________________	Y/N	Y/N	Y/N	Y/N
________________________	________________________________	Y/N	Y/N	Y/N	Y/N

Specific Instructions or Limitations:____

We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

Signature of Patient:____**Date:**___________________________

To revoke this authorization, please send a written request to our office.

Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

POLICY ACKNOWLEDGEMENTS AND RELEASES

Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

Signed: ____ Date: ________________________

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Dr. Thomas / Dr. Harnisch. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: ____ Date: ________________________

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: ____ Date: ________________________

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: ____ Date: ________________________

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

MEDICATION HISTORY AUTHORITY: I authorize BHS Physicians Network and BHS Physicians Specialty to obtain Medication History Authority.

Signed: ____ Date: ________________________

NO SHOW POLICY

Patients who fail to present for a scheduled appointment will be considered a “no show”. Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a “no show”.

A patient determined to be a “no-show” will be charged for each episode.

_______________________________ has read and understand the above stated policy.
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.

I, ____, DOB, ____________________,

have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

__________Individual refused to _______accept Notice ________ sign Acknowledgment

__________Communications barriers prohibited obtaining the acknowledgment

__________An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)____

Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ **PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or other applicable forms, there is a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ **APPOINTMENT TIME:** We ask that you arrive 15 minutes early for your appointments.

____ **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

____ **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours notice.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

________________________________	___________________________________	________
Patient Signature	**Printed Name**	**Date**

Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

New Patient Questionnaire:

Patient Name: ____________________________________ Date of Birth: ________________

What problem brought you here? ____

What symptoms are you having? ____

When did the symptoms begin? ____

Types of diets attempted with weight lost (please include dates)? ____

How many years have you been obese? ____

Please list weight loss medications you have used in the past____

Please list types of exercise you have attempted ____

Diet	Dates	Weight Lost

ALLERGIES
Are you allergic to any medications, pills, food, etc.?

Drug/ Allergen	Reactions?	Onset Date:

MEDICATIONS
Please list all medications or pills that you take, that you do not utilize your insurance to obtain or that are not prescribed by a physician. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

PAST MEDICAL / SURGICAL HISTORY
Please place a check next to any medical problems.

Medical History
Please carefully review the list of medical conditions/problems below and check any that apply to you:

- ❑ Angina
- ❑ Allergic Rhinitis
- ❑ Anxiety
- ❑ Asthma
- ❑ Breast Cancer
- ❑ Heart Disease w/bypass surgery
- ❑ Heart Disease without bypass surgery
- ❑ Cardiomyopathy
- ❑ Carpal Tunnel Syndrome
- ❑ Chest pain with exertion/exercise
- ❑ Gallstones
- ❑ Chronic Back Pain
- ❑ Congestive Heart Failure
- ❑ Stroke
- ❑ DVT (Blood Clot)
- ❑ Degenerative Disk Disease
- ❑ Depression
- ❑ Type I Diabetes/Insulin Dep (controlled)
- ❑ Type I Diabetes/Insulin Dep (Uncontrolled)
- ❑ Type II Diabetes/Adult Onset (Controlled)
- ❑ Type II Diabetes/Adult Onset (Uncontrolled)
- ❑ Abnormal Uterine Bleeding
- ❑ Dysmenorrhea (Excessively painful menses)
- ❑ Shortness of breath with exertion/exercise
- ❑ Abnormally elevated liver function tests
- ❑ Fatigue
- ❑ Fatty liver (due to alcohol)
- ❑ Fatty liver (NOT related to alcohol)
- ❑ Fibrocystic breast disease
- ❑ Fibromyalgia
- ❑ Acid Reflux Disease/GERD
- ❑ Gestational Diabetes (diab w/pregnancy)
- ❑ Glucose Intolerance
- ❑ Gout
- ❑ Heartburn/Indigestion
- ❑ Hemorrhoids
- ❑ High Cholesterol
- ❑ Hypertension (high blood pressure)
- ❑ High triglycerides
- ❑ Hypothyroidism (Underactive thyroid)
- ❑ Infertility
- ❑ Insomnia
- ❑ Intermittent Claudication
- ❑ Intertriginous Dermatitis (irritation of the skin folds)
- ❑ Irritable Bowel Syndrome
- ❑ Joint Pain
- ❑ Menstrual Irregularity
- ❑ Migraine Headaches
- ❑ Myocardial Infarction (Heart Attack)
- ❑ Swelling of the legs (edema)
- ❑ Peripheral Vascular Disease
- ❑ Stomach Ulcers
- ❑ Polycystic Ovarian Syndrome (PCOS)
- ❑ Pseudotumor Cerebrii
- ❑ Pulmonary Embolus (blood clot to lungs)
- ❑ Seasonal Allergies
- ❑ Sleep Apnea
- ❑ Sleeping Disorder
- ❑ Stress Urinary Incontinence (leaking urine)
- ❑ Thrombophlebitis
- ❑ Urinary Urge Incontinence (can't hold urine)
- ❑ Varicose Veins/ Venous Insufficiency

SURGICAL HISTORY
Please list any previous operations or procedures

Procedure / Operation	Date	Surgeon	Hospital

Patient Name: ______________________________ Date of Birth: ______________

Comprehensive Center for Weight Loss
BHS PHYSICIANS NETWORK

FAMILY HISTORY

Relation:	Problem: Ex: Stroke, Heart Disease, Diabetes, Hypertension, etc.,	Onset Age	Died of Age	Notes

SOCIAL HISTORY:
Please circle or complete the most applicable.

Smoking Status: Never Smoker/ Former Smoker/ Current every day smoker
If so, Has smoked since age: _____________
If so, How much: None/ 1 PPW /2 PPW/ 1/4 PPD/ 1/2 PPD/ 1 PPD 1 1/2 PPD/ 2 PPD/ 3+ PPD
Chewing tobacco : None/ 1 day/ 2-4 day/ 5+/day
Exercise level: None/ Occasional/ Moderate/ Heavy
Diet: Regular/ Vegetarian/ Vegan/ Gluten free Specific / Carbohydrate
General Stress Level: Low/ Medium/ High
Alcohol intake : None/ Occasional/ Moderate/ Heavy
Caffeine intake: None/ Occasional/ Moderate/ Heavy
Illicit drugs : _______________________________
Sunscreen used routinely: Y/ N
Does anyone living in your home smoke? Yes/ No

Patient Name: _______________________________________ Date of Birth: __________________