THE SURGICAL CLINIC
OF CENTRAL ARKANSAS

INFORMATION FOR CASE HISTORY FILE

DATE: _____ **(PLEASE COMPLETE ALL ITEMS. PLEASE PRINT)**

PATIENT INFORMATION

PATIENT'S NAME: _____ SS#:_____
First Middle Last

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED EMAIL: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ ALT. PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____

PHARMACY NAME: _____ PHONE NUMBER: _____

SPOUSE INFORMATION

NAME: _____ SS#:_____ D.O.B.:_____

EMPLOYER: _____ WORK PHONE: _____

PARENT INFORMATION (This section applies only if the patient is a minor & the parent is financially responsible.)

NAME: _____ SS#:_____ D.O.B.:_____

EMPLOYER: _____ WORK PHONE: _____

REFERRING DOCTOR INFORMATION

How did you find out about our clinic? _____

Referring Doctor's Name/Address: _____ Phone: _____

Family Doctor's Name/Address: _____ Phone: _____

EMERGENCY CONTACT INFORMATION (Please list nearest relative not living at the same address as the patient.)

Relative's Name & Address: _____

Relationship to Patient: _____ Phone: _____

Patient Name: _____

I hereby authorize payment directly to **The Surgical Clinic of Central Arkansas,** 9500 Kanis Rd, Suite 501, Little Rock, AR, 72205, of the medical benefits herein specified and otherwise payable to me, but not to exceed the clinic's regular charges for this period of treatment. I understand that I am financially responsible for the charges not covered by this authorization.

Authorization to Release Information: I hereby authorize **The Surgical Clinic of Central Arkansas,** and any other physicians or hospitals that have records, to release information requested by my insurance company in order to pay this claim.

Signature: _____ Date: _____

REASON FOR APPOINTMENT: _____

Height: _____ Weight: _____

ALLERGIES

Please list all allergies/adverse reactions to prescription or over the counter medications, tape, x-ray contrast or dyes, etc. Please list any additional information in the space provided or on a separate page. ***Place a check in the appropriate box to indicate the type reaction.***

☐ **NO KNOWN DRUG ALLERGIES** *** ARE YOU ALLERGIC TO LATEX? YES NO**

ALLERGY	RASH	HIVES WELTS	DIFFICULTY BREATHING	ITCHING	NAUSEA VOMITING	DIARRHEA	SHOCK	IRREGULAR HEARTBEAT	OTHER REACTION

Have you ever had a bad reaction to anesthesia? Yes____ No____ If so, what type reaction?_____

_____

_____

Have you ever had a bad reaction to local anesthesia (Lidocaine, Novocain)? Yes____ No_____ If so, what type reaction?

_____

_____

Has a member of your family ever had a bad reaction to anesthesia? Yes____ No____ If so, what type reaction?_____

_____

_____

Patient Name: _____

FAMILY HISTORY

Please indicate which of the following diseases are present in your family by placing ***a check in the appropriate column***.

DISEASE	MOTHER	FATHER	BROTHER	SISTER	CHILDREN
HEART ATTACK					
STROKE					
DIABETES					
HIGH BLOOD PRESSURE					
ASTHMA					
EMPHYSEMA OR BRONCHITIS (COPD)					
KIDNEY DISEASE					
HEART FAILURE					
BLOOD DISEASE					
CANCER:BREAST					
CANCER: COLON					
CANCER: OTHER					
CROHN'S DISEASE					
ULCERATIVE COLITIS					
EPILEPSY					
MENTAL DISEASE					
OBESITY					

SOCIAL HISTORY

Marital Status: (Please Circle One) Single Married Divorced Separated Widowed Domestic Partner

Diet: (Please Circle One) Regular Vegetarian Vegan Gluten-Free Low Carb Cardiac Diabetic Low Fat/Cholesterol

Caffeine Intake: (Please Circle One) None Occasional Moderate (2-6 cups daily) Heavy (6 or more cups daily)

Alcohol Intake: (Please Circle One) None Occasional Moderate Heavy

Tobacco – Cigarettes: (Please Circle One) Never Smoked Current Every Day Smoker Occasional Smoker Former Smoker

If you are or were a smoker please complete the following: _____# Packs per Day Number of Years Smoked_____

Smokeless/Chewing Tobacco: Yes No _____ Times per Day Number of Years Used_____

Illicit Drugs: Yes No Type/Name: _____

Is this visit due to a work related injury? Yes No Explain: _____

Is this visit due to an automobile crash injury? Yes No Explain: _____

Do you have a Living Will? Yes No

Are you willing to accept Blood Transfusions in an emergency? Yes No

Patient Name: _____

PREVIOUS SURGERY

Please list all previous surgeries in the space below or attach an additional page if needed.

PROCEDURE	DATE	HOSPITAL	SURGEON	COMPLICATIONS

PAST MEDICAL HISTORY

Please indicate which of the following you have or have had in the past by placing a check mark in the column, list any details in the blank area provided.

	Yes	Notes		Yes	Notes
Heart Failure			Gallstones		
Heart Attack			Acid Reflux/GERD		
Cardiac Arrhythmia			Ulcers		
Heart Murmur or Prolapse			Vomiting Blood/"Coffee Grounds"		
High Blood Pressure			Gastroparesis		
Stroke			Hepatitis		
High Cholesterol			Pancreatitis		
Blood Disease (Leukemia)			Ulcerative Colitis		
Blood Clots/DVT			Crohn's Disease		
Bleeding Problems			Diverticulitis		
COPD			Hemorrhoids		
Tuberculosis			Black or "Tarry" stool		
Pneumonia			Rectal Prolapse		
Asthma			Kidney Stones		
Sleep Apnea			Kidney Failure		
Lung Disease			Kidney Disease		
Thyroid Disease			Cancer		
Diabetes: type ____			Lupus		
Epilepsy			Rheumatoid Arthritis		
Rheumatic Fever			Osteo Arthritis		
Steroid Medications (Cortisone, Prednisone, ACTH) in the last 6 months			Glaucoma		

Other Medical History not listed above: _____

_____

REVIEW OF SYSTEMS **Patient Name:** _____

Please place a check in the box to indicate which of the following you have had in the last year.

General:

- ☐ Weight loss ☐ Fatigue ☐ Fever ☐ No Problem
- ☐ Weight gain ☐ Weakness ☐ Night Sweats

Skin:

- ☐ Rashes ☐ Moles ☐ Ulcers/Sores ☐ No Problem
- ☐ Dryness ☐ Changes in skin/hair/nails

Eyes:

- ☐ Blurring Vision ☐ Pain ☐ Dryness ☐ No Problem
- ☐ Flashes of Light ☐ Vision Halos ☐ Glasses
- ☐ Contacts ☐ Blindness (Circle One): Right Left Both

Ears:

- ☐ Drainage ☐ Ringing ☐ Earache ☐ No Problem
- ☐ Hearing Aide ☐ Hearing Loss (Circle One): Right Left Both

Nose:

- ☐ Nosebleeds ☐ Sinus Pain ☐ Congestion ☐ No Problem
- ☐ Deviated Septum ☐ Post Nasal Drip

Mouth:

- ☐ Sore Throat ☐ Bleeding Gums ☐ Teeth Problems ☐ No Problem
- ☐ Dry Mouth ☐ Snoring ☐ Dentures

Throat:

- ☐ Trouble Swallowing ☐ Hoarseness ☐ Lump/Masses ☐ No Problems

Heart & Circulation:

- ☐ Chest Pain/Pressure ☐ Irregular Heartbeat ☐ Lightheadedness ☐ No Problem
- ☐ Fast/Slow Heart rate ☐ Ankle Swelling ☐ Fainting Spells
- ☐ Low Blood Pressure

Lungs:

- ☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ No Problem
- ☐ Coughing up Blood ☐ Pleurisy ☐ Asthma
- ☐ Pneumonia ☐ Phlegm/Sputum

Patient Name: _____

Stomach & Intestines:

- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Vomiting
- ☐ No Problem
- ☐ Change in appetite
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Vomiting Blood
- ☐ Black/Tarry Stool
- ☐ Hemorrhoids
- ☐ Change in Bowel Habits

Urinary:

- ☐ Incontinence
- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ No Problem
- ☐ Pus in Urine
- ☐ Enlarged Prostate
- ☐ Increase Urinary Frequency

Falls Risk Assessment:

- ☐ Imbalance
- ☐ 2 or more falls in past year
- ☐ No Problem

Nervous System:

- ☐ Tingling of Body Parts
- ☐ Seizures
- ☐ Tremors
- ☐ No Problem
- ☐ Headaches
- ☐ Migraines
- ☐ Restless Legs
- ☐ Weakness
- ☐ Numbness (Circle One): Right Left

Hormones:

- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Hair Loss
- ☐ No Problem
- ☐ Excessive Thirst/Hunger

Blood:

- ☐ Easy Bruising/Bleeding
- ☐ Clotting Problems
- ☐ Anemia
- ☐ No Problems
- ☐ Enlarged Lymph Nodes

Psychological:

- ☐ Loss of Interest
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ No Problems
- ☐ Nervousness/Anxiety
- ☐ Alcohol/Drug Abuse
- ☐ Difficulty Concentrating

Genitals:

- ☐ Erectile Difficulties
- ☐ Sores
- ☐ Hernias
- ☐ No Problems
- ☐ Testicular Pain/Mass
- ☐ Groin Swelling
- ☐ Breast Lumps
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Painful Intercourse
- ☐ Bleeding Between Periods

_____ _____ _____

Patient Signature **Date** **Physician Signature**

Patient Name: _____

Dear Patients,

Our office is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients.

As a part of this program, the government requires us to record the following demographic information about you:

•Preferred language •Date of Birth •Gender •Race •Ethnicity

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential.

You can help us by reviewing the list of options below and providing your race and ethnicity information during check in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

The Surgical Clinic of Central Arkansas

Please indicate your preferred language: _____

Please identify your race from the following CDC – defined options:

- ☐ African
- ☐ American Indian
- ☐ Arab
- ☐ Asian
- ☐ Black or African American
- ☐ Cambodian
- ☐ Chinese
- ☐ European
- ☐ Pilipino
- ☐ Haitian
- ☐ Indonesian
- ☐ Jamaican
- ☐ Thai
- ☐ Japanese
- ☐ Korean
- ☐ Middle Eastern
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Polynesian
- ☐ Vietnamese
- ☐ West Indian
- ☐ White

☐ Other: _____

Please identify your Ethnicity from the following CDC- defined options:

- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino/Spanish
- ☐ Latin American/Latin/Latino
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

Patient Name: _____

MEDICATIONS

Please list all prescription and over the counter medications, vitamins, or herbal supplements.

MEDICATION	DOSAGE	FREQUENCY	USED FOR

I agree that The Surgical Clinic of Central Arkansas may request and use my prescription medication history from other healthcare providers or Third Party pharmacy benefit payers for treatment purposes.

_____

Signature of Patient or Guardian Date

I give my consent to receive automated phone calls from The Surgical Clinic of Central Arkansas on my mobile phone.

_____

Signature of Patient or Guardian Date

THE SURGICAL CLINIC
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History of Obesity

Please complete each section, do not leave blanks. PLEASE PRINT.

Patient Name: _____ Date: _____

Social History

1. Did you graduate High school? Yes___ No___ If No, Highest grade completed _____
2. Occupation: _____
3. Please circle one: Full- time Part-time Homemaker Retired Student Disabled Unemployed

Weight History

1. Height (barefoot) _____ Present Weight _____
2. What is the most you have ever weighted? _____lbs.
3. How long have you been at least 75lbs. overweight? _____ years
4. Have you ever had previous surgery for weight loss? Yes ___ No ___
   If yes, when? _____ Type of operation _____
   Surgeon _____ Address _____

Diet History

1. Physician supervised diets

Diet	Physician	Date	Duration	Amount Lost	Weight Regained? Y	N
Low- Fat						
Low-Cal						
Diabetic						
High Protein						
Low Carb						
Dietician						
Other _____						

2. Diet Pills

Medication	Physician	Date	Duration	Amount Lost	Weight Regained? Y	N
Phen-Fen						
Meridia						
Apidex/Fastin						
Redux						
Xenical						
Bontril						
Ionamin						
Alli						

3. Commercial Diets

Diet Program	Physician Supervised? Y	N	Date	Duration	Amount Lost	Weight Regained? Y	N
Jenny Craig							
Nutrisystem							
Weight Watchers							
Optifast							
Medifast							
T.O.P.S							
Atkins Diet							
Slim Fast							
Overeaters Anonymous							
The Diet Center							
Hypnosis							
_____							

4. Please list any other diets or weight loss methods you have tried:

   _____

   _____

5. Please check the box that best describes your eating patterns:

☐ **Volume Eater**

I consume larger amounts of foods, especially foods that I enjoy. I enjoy sweets as well but only snack or stress-eat occasionally

☐ **Sweets Eater**

I prefer foods high in sugar (i.e. candy, cookies, etc.). I will eat less of normal food to save room for sweets. I drink non-diet beverages or sweetened liquids. I eat snack and stress-foods that are usually high in sugar.

☐ **Snacker**

I usually don't eat regular meals. I frequently eat fast food and select foods that are high in calories (high fat & high carb). I eat between meals & am not generally hungry at meal times. I seem to be constantly "grazing" on food.

Additional Medical History

1. Heart disease
   a. Congestive Heart Failure (CHF) Yes___ No___
   b. Irregular Heart Rate: _____ Yes___ No___
   c. Valve disease/replacement Yes___ No___
   d. Do you have a pacemaker? Yes___ No___

2. Sleep Disturbances
    a. Have you had a sleep study? Yes___ No___
    b. Do you have sleep apnea? Yes___ No___
    c. Were you placed on a CPAP/BiPAP? Yes___ No___
    d. Do you still use the CPAP/BiPAP? Yes___ No___
    e. Do you have loud snoring? Yes___ No___
    f. Have family members observed pauses in your breathing lasting 30 seconds? Yes___ No___
    g. Do you sleep on multiple pillows to elevate the head or your bed to improved breathing? Yes___ No___
    h. Do you have exhaustion or trouble staying awake during daytime hours or while working? Yes___ No___
3. Joint pain/Arthritis
    a. Circle the weight bearing joints involved: low back, hips, knees, ankles, feet
    b. Degenerative or osteoarthritis (wear & tear) Yes___ No___
    c. Do you have Rheumatoid arthritis? Yes___ No___
    d. Do you have Gout? Yes___ No___
    e. Have you had testing (lab or x-rays) for arthritis Yes___ No___
4. Blood diseases
    a. Have you ever had blood clots in the legs? Yes___ No___
    b. Have you had a blood clot in your lungs? Yes___ No___
        -If so do you have a filter in place? Yes___ No___
    c. If you have had bloods clots before, when? _____
    d. Were you placed on blood thinners? Yes___ No___
    e. Have you been diagnosed with HIV/AIDS? Yes___ No___
5. Gastrointestinal diseases
    a. Do you have acid reflux or GERD? Yes___ No___
    b. What testing have you had for this (e.g. x-rays, scoping of the stomach) _____
    c. Do you have a hiatal hernia? Yes___ No___
    d. Have you ever had surgery for reflux Yes___ No___
    e. Have you had ulcers? Yes___ No___
    f. What testing was done to diagnose ulcers (e.g. x-rays, scoping of the stomach) _____
    g. Are you on medication to treat /prevent ulcers Yes___ No___
6. Mental disease
    a. Do you have depression? Yes___ No___
    b. Do you have Bipolar Disorder? Yes___ No___
    c. Do you have Schizophrenia? Yes___ No___
    d. Do you see a therapist/psychiatrist? Yes___ No___
    e. What medications do you take for these problems? _____
    f. Any drug or alcohol addiction? Describe treatment: _____
7. Urinary/Reproductive
    a. Any urinary leakage or stress incontinence? Yes___ No___
    b. Women: Irregular Periods? Yes___ No___
    c. Women: Heavy Periods? Yes___ No___

The Surgical Clinic
Of Central Arkansas

Insurance Questionnaire

Important! In order for us to start the insurance approval process & get you approved in a timely manner we need the following information from your insurance company. Please use this form when you call your insurance company. Ask ALL of the questions and fill in ALL of the spaces as you talk with your insurance customer service representative. Return this form to us with your patient information forms.

Patient Name: _____

Insurance Company: _____

Insurance Company phone number called: _____ Date called: _____

Name of Representative: _____

Call back number for Customer Service Representative: _____

Questions you should ask:

1. Is there exclusion for morbid obesity (diagnosis code E66.01) on my policy? _____
2. Is surgery for morbid obesity a covered benefit? _____
3. What is the benefit level for the surgical treatment of morbid obesity? (Is it 80/20? 60/40? Or 50? etc.)
   -In Network benefit level _____ -Out of Network level _____
4. Is Lap-Band surgery a covered benefit (CPT code 43770)? _____
5. Is the sleeve Gastrectomy a covered benefit (CPT code 43775)? _____
   a. Are there additional qualification criteria for the sleeve (BMI greater than 50)? _____
6. Is the Gastric Bypass a covered benefit (CPT code 43644)? _____
7. What criteria must be met for approval? _____
   _____
8. Do I need a psychiatric evaluation? _____
9. So I need a consultation or evaluation by a dietitian before insurance approval? _____
10. Do I need to submit chart notes showing supervised weight loss attempts? _____
    a. How many months? _____
    b. How recent should they be? _____
11. Is there any specific testing that is required for approval? (e.g. blood work, cardiac clearance, ulcer screening)
    _____
12. Is there any additional information/records the insurance company will need? _____
13. What is the fax number for records to be sent for prior authorization/medical review?

THE FAX NUMBER IS A MUST! _____