Advanced BARIATRICS

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

MR. MRS. MISS. MS. PATIENT'S LAST NAME	FIRST	MIDDLE	MARITAL STATUS *(Circle one):* SINGLE MARRIED DIVORCED SEPARATED WIDOW
IS THIS YOUR LEGAL NAME? YES NO IF NOT, WHAT IS YOUR LEGAL NAME (FORMER NAME)?	BIRTH DATE / /	AGE	SEX M F

STREET ADDRESS:	SOCIAL SECURITY # *(Last 4 only)* 000-00-	HOME PHONE ( )
CITY / STATE / ZIP:	EMAIL:	CELL PHONE ( )
OCCUPATION:	EMPLOYER:	WORK PHONE ( )

WHO REFERRED YOU TO OUR OFFICE? FAMILY FRIEND CLOSE TO HOME / WORK INTERNET
DR._____ INSURANCE PLAN HOSPITAL OTHER _____

PRIMARY CARE PHYSICIAN NAME/ADDRESS:

PREFERRED PHARMACY NAME AND CITY:

Race: Caucasian Asian African-American Hispanic Hawaiian/Pacific Islander Prefer not to answer

Ethnicity: Hispanic Non-Hispanic Prefer not to answer

INSURANCE INFORMATION

INSURANCE COMPANY #1	INSURED'S NAME	INSURED'S BIRTH DATE / /
INSURANCE COMPANY #2	INSURED'S NAME	INSURED'S BIRTH DATE / /

PERSON RESPONSIBLE FOR THE BILL:

IN CASE OF EMERGENCY

NAME:	HOME PHONE ( )
RELATIONSHIP TO PATIENT:	CELL PHONE ( )

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.** I ALSO AUTHORIZE ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____
Name *Date*

Your answer on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank You.

Date of Birth:_____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Current Height_____ Weight_____ Other concerns:_____

MEDICAL HISTORY

Have you ever had anesthesia? Yes No Did you experience any of the following:
Airway problem? Malignant hypothermia (High fever during surgery?)

Do you smoke? Yes No Former How many packs per day?_____How many years?_____

Do you consume alcohol? Yes No Quantity?_____How often?_____

Does your medical history include any of the following (circle if applicable):

Asthma	Bronchitis	Anemia	Hypertension/High Blood Pressure
Heart Attack	Irregular Heart Beat	Emphysema	Stomach Ulcer
Mitral Valve Prolapse	Swelling in hands or feet	Chest pain	Joint stiffness or Arthritis
Diabetes	Hepatitis or jaundice	Kidney problem	Back pain or injury
Thyroid problem	Epilepsy or seizures	Heart Pacemaker (please have card available)	
Tuberculosis	Stroke	Cancer (type):_____	

Other (please specify):_____

MEDICATIONS:

Medication/Vitamin/Supplement	Dosage/Strength (e.g. mg/pill)	How many times Daily?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

FAMILY HISTORY:

Check all that apply	MOTHER	FATHER	OTHER RELATIVES (please specify)
Cancer (please specify)			
Heart Disease			
Diabetes			
Stroke			
Hypertension (high blood pressure)			
Other (please specify)			

ALLERGIES: Do you have allergies or reactions to:

Medications	**Reaction**	**Foods**	**Reaction**

Please list other additional physicians:

Psychiatrist/Psychologist:_____

Address:_____

Phone:_____Fax:_____

Orthopedic:_____

Address:_____

Phone:_____Fax:_____

OB/GYN:_____

Address:_____

Phone:_____Fax:_____

How did you hear about our program?

Friend Family Doctor TV Radio Newspaper Internet Other_____

What weight loss surgery are you interested in?

Roux-en-Y Gastric Bypass Gastric Band Sleeve Gastrectomy Revision Unsure

Have you ever had bariatric surgery? Yes No

If yes, what surgery and when? _____

Habits:

Do you drink caffeine? Yes No
Type: Coffee (___ cups/day) Soda (___ cups/day) Tea (___ cups/day)

Do you use recreational drugs? Yes No
Type: Marijuana (___/week) Cocaine(___/week) Heroin(___/week) Other

Weight Loss History:

Height:_____Weight:_____BMI:_____

Highest Adult Weight:_____Lowest Adult Weight:_____

My obesity started: in childhood at puberty as an adult after pregnancy
after a traumatic event other _____

Additional notes regarding the onset of obesity:_____
_____
_____

Taste Preferences:
Sweet Salty Fast Food Comfort Foods Other _____

Eating Habits:
Binge Eater Night Eater Grazer/Snacker Emotional Eater

Do you: Over Eat Over Indulge Binge Eat?
(Over eating is when you plan to eat a normal amount and you overeat but not to the point of feeling like you may vomit. Over indulgence is when you plan to eat too much but not to the point of wanting to vomit. Binge eating is defined as eating a large amount of food during a short period of time, typically no more than 2 hours, while feeling out of control to stop eating.)

Do you purge (make yourself vomit after a meal)? Yes, how often _____/day No

Approximate age when you first seriously dieted?_____

Weight Loss Programs/Diets/Medications: (Please list type and dates)

Diet Program	Year and Duration	Total Weight Loss	Documentation Available? Yes or No
Atkins/Zone			
Dietitian			
HCG (Releana)			
Jenny Craig			
Metabolife			
Nutri System			
Opti/Medi Fast			
Phentermine/Fen-Fen			
Physician Supervised			
Weight Watchers			
Other:			

Have you been on any kind of steroids in the last 12 months?_____

Exercise History:
Are you currently participating in a regular exercise program? Yes No

Do you have physical limitations that make increasing activity level difficult? Yes No
If yes, please explain:_____

Do you have concerns regarding exercise and increase in physical activity? Yes No
If yes, please explain:_____

Exercise History for the Past 12 Months:

Type of Program (Walk/Run/Jog/Swim/Dance/Bike/ Yoga/Strength Training/Etc.)	Start Date	End Date	Frequency and Duration per Week

How far can you walk without having difficulty? < 1 Block < ½ Mile < 1 Mile > 1 Mile

When you go past this distance, what limits your ability to continue?_____

How many stairs can you climb without difficulty?_____

Additional Health Information:

Please circle if you have any of the following medical conditions:

Acid Reflux	Depression	Leg Cramping
Alcoholism	Diverticulitis	Liver Disease
Allergies	DVT	Lung Disease/Pneumonia
Angioplasty w/Stent	Easy Bruising	Migraine/Severe Headaches
Anxiety	Frequent Nausea	MRSA
Bladder Infections	Gallbladder Disease	Osteoporosis
Bleeding Disorder	Gout	Oxygen Dependent
Blood Transfusion	Heart Failure	Psychiatric Problems
Bowel Incontinence	Heart Bypass or Stents	Pulmonary Embolism
Breathing Problems/Shortness of Breath	Heart Disease	Rash/Dermatitis
Bulimia/Excessive Vomiting	Hemorrhoids	Sleep Apnea
Cardiac Surgery	Hernia	Steroid Use for Chronic Condition
Colitis	High Cholesterol	Urine Leakage
Constipation	HIV/AIDS	Venous Stasis
COPD	Irritable Bowel Syndrome	
Currently on Blood Thinners	Kidney Disease	

Functional Health Status: Independent Partially Dependent Totally Dependent

Is your mobility limited? Yes All of the time Some of the time No

Have you fallen in the last year? Yes, explain_____ No
Were you injured? Yes, explain _____ No

Women Only:

Date of last menstrual period:_____Are your menstrual periods regular?_____

Are you using birth control? Yes, name: _____ No

Number of Pregnancies:_____Number of Live Births:_____

Are you experiencing menopausal symptoms? Yes No

Have you completed menopause? Yes No

Are you on Hormone Replacement Therapy? Yes No

Review of Systems

Please circle the appropriate response and answer all questions completely.

Constitutional Symptoms

Yes No Fever Yes No Chills
Yes No Headache Yes No Other

Eyes

Yes No Blurred Vision Yes No Pain
Yes No Double Vision Yes No Other

Ear/Nose/Throat/Mouth

Yes No Ear Infection Yes No Sore Throat
Yes No Sinus Problems Yes No Other

Respiratory

Yes No Wheezing Yes No Frequent Cough
Yes No Other Yes No Shortness of Breath

Gastrointestinal

Yes No Abdominal Pain Yes No Nausea/Vomiting
Yes No Indigestion Yes No Stomach or duodenal ulcer
Yes No Heartburn Yes No Other

Genitourinary

Yes No Urine Retention Yes No Painful Urination
Yes No Urinary Frequency Yes No Problems leaking urine
Yes No Other Yes No Problems with menstruating

Musculoskeletal

Yes No Joint Pain Yes No Neck Pain
Yes No Back Pain Yes No Other

Integumentary

Yes No Skin Rash Yes No Persistent itching
Yes No Boils Yes No Other

Neurological

Yes No Tremors Yes No Dizzy Spells
Yes No Other Yes No Numbness / Tingling
Yes No Other

Endocrine

Yes No Excessive Thirst Yes No Do you have Diabetes?
Yes No Tired / Sluggish Yes No Too Hot / Too Cold
Yes No Other

Cardiovascular

Yes No Chest Pains Yes No High Blood Pressure
Yes No Varicose Veins Yes No Swelling in Legs
Yes No Ulcer or non-healing sores on your legs?
Yes No Ever seen a Cardiologist?
Yes No Had a heart attack or any other heart problems?
Yes No Other

Hematologic/Lymphatic

Yes No Swollen Glands Yes No Blood Clotting Problem
Yes No Other

Allergic/Immunologic

Yes No Hay Fever Yes No Drug Allergies
Yes No Other

Psychological

Yes No Are you generally satisfied with your life?
Yes No Do you feel severely depressed?
Yes No Have you considered suicide?
Yes No Other

Other Questions

Yes No Have you been diagnosed with: HIV AIDS Hepatitis B Hepatitis C
Yes No Do you snore?
Yes No Have you ever been told that you stop breathing when you sleep?
Yes No Have you ever fallen asleep at the wheel?
Yes No Do you have to take a nap every day?
Yes No Do you feel rested when you make up in the morning?
Yes No Do you wake up (from a deep sleep) choking or coughing?
Yes No Have you ever been told you have sleep apnea? Do you use c-pap or bi-pap?
Yes No Have you ever had surgery for weight loss?

Advanced
SURGICAL CARE
of Northern Illinois, LTD.

Advanced Surgical Care of Northern Illinois

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Advanced Surgical Care. When you schedule an appointment with Advanced Surgical Care, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible. This should be done no later than 24 hours prior to your scheduled appointment. If you are running late, please notify the office. If a patient arrives more than **10 minutes** past their scheduled time, our office staff will need to reschedule your appointment and our no-show policy terms will apply.

Effective January 1, 2025, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice will be considered a No Show and charged a **$50.00 fee**.

- Any established patient who fails to show or cancels/reschedules an appointment without 24-hour notice a **second time** will be charged a **$60.00 fee**.

- If a **third** No Show or cancellation/reschedule without 24-hour notice should occur with a year's time, the patient may be **dismissed from Advanced Surgical Care.**

- Any new patient who fails to show for their initial visit will not be rescheduled.

- These fees are the responsibility of the patient, not the insurance company, and are **due prior to the patient's next office visit.**

We understand there may be times when an unforeseen emergency may occur, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee. You may contact Advanced Surgical Care during regularly scheduled office hours at the numbers below. Voicemail messages can be left, and we will attempt to call you back once received. Given the sometimes-unreliable nature of voicemail, cancellation of an appointment is not official until the patient has spoken directly with one of our staff members. We will also accept appointment cancellations via our Live Well portal.

Advanced Surgical Care 847-381-8161

I have read Advanced Surgical Care's Cancellation/No Show Policy and agree to its terms. I understand that these terms are renewable each year and do not require additional signatures in subsequent years. A paper copy of this policy is available upon request.

_____ _____ _____

Signature **Name** **Date**

Advanced SURGICAL CARE of Northern Illinois, LTD.

Daniel T. Hoeltgen, MD, FACS, FASMBS
David P. Ondrula, MD, FACS, FASCRS
Gia M. Compagnoni, MD, FACS
Hsin-Yi Chang, MD FACS
John R. Cheregi, MD, FACS, FASMBS
Jill R. Motl, MD
Vanessa Manzo, MSN, FNP-C

Pre-Surgery Deposit

Prior to undergoing surgery with our surgeons at Advanced Surgical Care of Northern Illinois, Ltd., we will require a pre-surgery deposit to schedule your surgical procedure. To clarify the necessity of collecting this deposit, we have outlined the extensive process involved to schedule your surgery to include but is not limited to:

- The operating room and anesthesia team are secured for the procedure.
- The assistant (if needed) is requested and secured for the procedure.
- Coordination with a co-surgeon (when required) is provided.
- Our surgery scheduler/coordinator requests and obtains necessary pre-operative testing and medical clearance in timely manner for review not only by your surgeon, but also for pre-admitting to prevent a delay or cancellation by the hospital.
- The hospital holds the practice responsible for utilization of the operating room.
- Other patients who would desire the current operating room time reserved on your behalf have to be deferred.

The Surgical Deposit Agreement is outlined below. When you feel you understand the contents of the form, and agree to the terms, please sign, and date on the line indicated below.

I agree to submit a $_____ surgical deposit at the time I request my surgery to be scheduled. This deposit will be applied to the balance your insurance company deems to be your patient responsibility as applied to your deductible and out of pocket. The operating room, anesthesia fees and hospital fees are not included in Advanced Surgical Care's cost, and I understand I may owe an additional amount to Advanced Surgical Care after my claim is submitted to my insurance. If you have met your deductible and out of pocket and have no outstanding balance with Advanced Surgical Care, this deposit will be refunded after the surgical procedure is completed.

Cancellation and Rescheduling Policy:

**Cancellation/rescheduling at least 4 weeks prior to surgery date- Full refund of deposit.

**Cancellation/rescheduling at least 3 weeks prior to surgery date- 50% refund of deposit.

**Cancellation/rescheduling less than 2 weeks prior to surgery date- Forfeiture of deposit.

There will be no funds held if our office needs to cancel or in the event of a documented medical reason with a treating physician's statement.

I understand and agree to the above terms.

Please sign and return.

Signature: _____ Date: _____

Advanced SURGICAL CARE of Northern Illinois, LTD.

CONSENT FOR RELEASE OF HEALTH INFORMATION

Patient name: _____

Date of Birth: _____

Please specify if we can leave you a detailed message (circle one):	
Leave Detailed Message Yes No	Leave Detailed Lab/Test Results Yes No

*Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

Please list any persons with whom we **MAY** share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV, Drug/Alcohol treatment and or Genetic testing.

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Advanced Surgical Care locations and Physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Name	Relationship	Release SHI? (circle one)
		Yes No
		Yes No
		Yes No
		Yes No

Signature of Patient or Responsible Party if a minor:_____

Date: _____