ADVANCED BARIATRIC AND SURGICAL SPECIALISTS

Craig G. Chang, M.D., F.A.C.S

HEALTH QUESTIONNAIRE

Please complete the 2 page document and return or fax to the contact information below. Our office staff will review your information to determine eligibility for surgery. We will contact you to schedule your initial consultation. You may be seen by a Nurse Practitioner during at our clinic; your picture will be taken at the initial consultation to be used for identification purposes and uploaded to our Electronic Health Records.

Date_____ (page 1/2)

PATIENT NAME_____
FIRST MI LAST

MAILING ADDRESS _____ CITY _____ STATE_____ ZIP _____

HOME PHONE_____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS_____ May we leave you a message? [ ] Y/N

SOCIAL SECURITY #_____ BIRTHDATE _____ AGE_____ SEX____

MARITAL STATUS: Select [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] DOMESTIC PARTNERSHIP

PREFERRED LANGUAGE: Select [ ] ENGLISH [ ] SPANISH

RACE: Select [ ] WHITE [ ] AFRICAN AMERICAN [ ] AMERICAN INDIAN [ ] PACIFIC ISLANDER [ ] HISPANIC [ ] ASIAN

ETHNICITY: Select [ ] NOT HISPANIC OR LATINO [ ] HISPANIC OR LATINO

PATIENT'S EMPLOYER_____ PHONE_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT PHONE_____RELATIONSHIP_____

FAMILY DOCTOR (PCP): _____

Which other physicians do you see on a regular basis?_____

****INSURANCE INFORMATION****

Provider: _____ Policy Holder Name _____
Policy Holder Date of Birth: _____ Relationship to patient _____
Insurance ID # _____ Employer _____
Group # _____ Referral Authorization Tel _____

Secondary Insurance [ ] Y/N Provider _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? Check all that apply

[ ] Diabetes mellitus	**[ ] Hypertension**	**[ ] Sleep apnea**
[ ] Joint pain (arthritis)	**[ ] GERD (Acid reflux)**	**[ ] Urinary stress incontinence**
[ ] Asthma	**[ ] Congestive heart failure**	**[ ] Heart attack**
[ ] Depression	**[ ] Infertility**	**[ ] Deep vein clots**
[ ] Shortness of breath	**[ ] High cholesterol**	**[ ] heavy/irregular periods**

Please list any other medical problems you have ever been diagnosed with_____
_____

List any medications (or bring a list with you) _____
_____
_____

Are you allergic to any food or medication [ ] Y/N _____

Have you ever had surgery? Please list type of surgery with approximate dates.
_____
_____

Height: _____ Weight: _____
Have you ever had previous obesity surgery? [ ] Y/N What type? _____ When? _____
Name of surgeon or institution_____
Previous weight loss attempts _____

How did you hear about us? (Check all that apply)

- ☐ Internet (search engine)
- ☐ www.gastricsleeves.org
- ☐ www.absspecialists.com
- ☐ Other website _____
- ☐ Television Commercial
- ☐ Billboard
- ☐ Company health fair
- ☐ Friend: _____
- ☐ Physician Referral: _____
- ☐ Postcard/Brochure
- ☐ Facebook
- ☐ Support Group
- ☐ Newspaper Advertisement
- ☐ Other: _____

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I the undersigned, by presenting for services, request and authorize evaluation, diagnosis and treatment by my physician and/or his/her designee. I further hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits without obtaining my signature on each and every claim.

AS A COURTESY TO YOU, we will file your insurance claim. It is your responsibility to see that your insurance pays on time. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You may be asked to pay a portion of the charges prior to scheduling surgery. Failure to pay your bill could result in your account being turned over to a collection agency.

I hereby authorize my insurance benefits to be paid directly to Craig G. Chang, MD, PA and acknowledge that I am financially responsible for all charges as a result of services rendered to me.

Signature_____ **Date**_____