HealthONE Denver Center for Bariatric Surgery
Physician Care℠

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www.denverbariatrics.com

New Patient Assessment

Name: ____ Date:________________

Date of Birth: _________________ Height (ft & in): _______________ Weight (lbs.): ______________

Primary Insurance: ________________________ ID #: ____________________________________
Secondary Insurance: ________________________ ID #: ____________________________________

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

Referral Physician:__________________
Denver Center for Bariatric Surgery website
Friend/Family/Previous patient
Google/Web search
Healthgrades
Other healthcare facility: _____________
Instagram
Facebook
Twitter
YouTube
Other Source: _________________

Please list the names of your current medical providers:

Primary Care Provider Name: ____
Address: ____
Phone: ____

Other Provider: ____
Phone: ____________________________ Specialty: _______________________________________

Other Provider: ____
Phone: ____________________________ Specialty: _______________________________________

Pharmacy Name: __________________________________ **Phone**: __________________________
Address: ____

Revised 3/2022

Medical History

Please list your prescribed, over-the-counter, or herbal medicines, including doses and number of times per day taken:

#	Name	Strength	Take	Frequency	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Please list any current medical conditions and date of diagnosis (if known)

#	Condition	Date of diagnosis
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list any allergies and your reactions:

#	Agent/Substance	Reaction
1.		
2.		
3.		
4.		
5.		

Patient Name: ____ DOB: ______________

Revised 3/2022

Please check the answer that applies to you:

IMPORTANT: Do you accept blood products in case of emergency?	Yes ☐	No ☐	
Have you had a flu vaccine in the last year?	Yes ☐	No ☐	Date___________
If over 65, have you had a pneumonia vaccine in the last year?	Yes ☐	No ☐	
If over 65, have you had any falls in the last year?	Yes ☐	No ☐	Date___________
Have you had COVID-19 in the past?	Yes ☐	No ☐	Date___________
Have you had a COVID-19 vaccine in the last year?	Yes ☐	No ☐	

If yes: Vaccine name ______________________________

Date 1st dose ______________________________

Date 2nd dose______________________________

Date booster ______________________________

Please write what you feel the doctor and bariatric team needs to know about you (<u>not</u> required):

Patient Name:____DOB: ______________

Revised 3/2022

Please list any previous surgeries and dates.

#	Date (Mo/Yr)	Surgery
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Please list any previous hospitalizations and dates.

#	Date (Mo/Yr)	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Patient Name:____DOB: ______________

Please <u>check</u> only if any of your blood relatives have a history of any of the following:

Family Members	Alive/ Deceased	Obesity	Diabetes	High Blood Pressure	Bleeding Tendency	Blood Clots	Cancer	Heart Attack	Stroke	Reaction to Anesthesia
Mother										
Father										
Sister(s)										
Brother(s)										
Daughter(s)										
Sons(s)										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Other significant family history:

____

____

____

Patient Name: ____ DOB: _______________

Revised 3/2022

Social History

Please check the answer that applies to you.

Do you drink alcohol? Yes ______ No ______

How often/How much? ___________

Do you have a history of alcoholism? Yes ______ No ______

Do you smoke? Yes ______ No ______

If you smoked previously, when did you quit: _________________________

Do you vape? Yes ______ No ______

Do you chew? Yes ______ No ______

Do you use marijuana/edibles? Yes ______ No ______

Have you ever had recreational drug abuse? Yes _____ No _____

Drug(s) ____

Are you: Single ______ Married ______ Partnered ______ Living with a significant other ______

What is your occupation? ____

Patient Name: ____ DOB: ____________

Revised 3/2022

Review of Systems

Please check if **you** have experienced any of the following:

C/V:

High blood pressure	________	Heart disease/Heart attack history	_______
CHF	________	Chest Pain	_______
Chest pain with activity	________	Irregular heart beat/murmur	_______
Stroke	________	TIA	_______
High cholesterol	________	High triglycerides	_______
Blood clots in legs	________	Blood clots in lungs	_______

Resp:

Sleep apnea	________	CPAP ______ Settings _________________	
Home oxygen use	________	=> During day ______ At night ______	
Snoring	________	Shortness of breath	________
Asthma	________	COPD/Emphysema	________
Difficulty breathing w/exertion	________		

GI:

Heartburn/Reflux	________	Stomach ulcers	________
Problem eating/swallowing	________	Abdominal pain	________
Inflammatory bowel Disease	________	Irritable bowel disease	________
Rectal bleeding/Blood in stool	________	Pain with fatty foods	________
Gallstones	________	Hiatal hernia	________
Gallbladder surgery	________	Liver or pancreas problems	________
Diarrhea	________	Constipation	________
Upper Endoscopy/scope (when)	________	**Colonoscopy**/Lower scope (when)	________

Endo:

Diabetes I / II (circle one)	________	Pre-diabetes	________
Low thyroid	________	Hirsutism (Increased hair)	________
# of pregnancies	________	# of children	________
Oral contraceptives used	________	Irregular periods	________
Hot flashes	________	Sexual dysfunction	________
Polycystic ovarian syndrome (PCOS)	________	Other ____________________________________	

Musc:

Joint pain	________	Where? ________________________________	
Arthritis	________	Where? ________________________________	
Leg swelling	________	Varicose veins	________
Leg ulcers	________	Peripheral vascular disease	________

Patient Name: ____ DOB: _______________

Revised 3/2022

GU:	Urinary stress incontinence	_______	Losing urine	_______
	Kidney stones	_______	Prostate problems	_______
	Blood in urine	_______	Pain with urination	_______
	Erectile dysfunction	_______	Urination frequency	_______
Heme:	Anemia (low blood count)	_______	Bruising	_______
	Blood clots	_______	Bleeding or Clotting problems	_______
	Embolism to lungs	_______	Low iron levels	_______
	History of transfusions	_______		
Com:	HIV/AIDS	_______	Hepatitis A B C	_______
	TB	_______		
Neur:	Seizures/Convulsions	_______	Neuropathy/Numbness	_______
	Migraines	_______	Headaches	_______
	Fatigue	_______	Confusion	_______
	Dizziness	_______	Difficulty walking	_______
	Weakness	_______		
CA:	Any type of cancer	_______	Where? ______________________________	
	Last mammogram (women)	_______		
Psy:	Depression	_______	Anxiety/Panic	_______
	Bipolar	_______	Though	_______
	Other mood disorders	_______	Memory changer	_______
	Low motivation	_______	Suicidal thoughts	_______
	Stress	_______	Sexual abuse (optional)	_______
	Eating disorder	_______	Other psychiatric problems	_______
	Required hospitalization	_______	On psychiatric medicines	_______

If seeing a Psychiatric Professional, please list name and contact information:

Name: ______________________________

Phone: ______________________________

Patient Name: ____ DOB: _______________

Weight History
(for Bariatric Consult only)

When your weight first became a problem to you:

____ Always
____ In high school
____ As young adult
____ After children
____ Later in life

Maximum weight you have ever been: __________

Please check all weight loss plans you've attempted:

Fen-Phen	Phentermine	Redux	Xenical
Qsymia	Contrave	Saxenda	Meridia

Other prescription: __________________

Please check all physician monitored diet you have attempted:

MediFast	Metabolife	Herbalife	Slim4Life
Jenny Craig	LA weight loss	Sugar Busters	Overeaters anonymous
Zone	Hyspnosis	Acupuncture	Hydroxycut
South Beach	Richard Simmons	Body of Life	Intermittent Fasting
Psychotherapy	Biggest loser	Calorie counting	Keto
Ephedra	Ornish diet	Keto diet	Noom
Grapefruit diet	Fasting	Weight Watchers	
Diet Centers	Nutrisystem	Atkins	

Other exercise programs attempted: ____

Exercise Program

Gym Membership(s)	Pilates
Walking	CrossFit
Jogging/Running	Trainer
Yoga	SpinBiking
Weight Lifting	Peloton

Other exercise programs attempted: ____

Patient Name: ____ DOB: ____________

Revised 3/2022

*This Form to be used in Conjunction with Form entitled “Consent for Use and Disclosure of Image, Voice and/or Written Testimonials”.

Facility: ______________________________

Patient Identification

Printed Name: ______________________________ Date of Birth: ______________

Address: ______________________________

____

Last Four Digits SSN (optional): ______________ Telephone: ______________

Information To Be Released – Covering the Periods of Health Care

From (date) ______________ to (date) ______________

Type of information to be released: Video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials and statements, including biographical information, of the individual identified above.

Purpose of Request

To videotape, photograph and record audio of patients for the facility's marketing purposes, including but not limited to production of recordings, brochures, advertisements, videos and similar image and sound capture for purposes of publication and/or distribution via all types of media.

Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to the facility for this use of protected health information.

Check One: ☐ **Yes** ☐ **No** ____________ **Initials**

Persons Authorized to Receive Information

I agree that the publication and distribution of the protected health information described herein may and likely will include distribution of such information to the general public via various methods, including all types of media outlets (e.g., TV, radio, newspaper, Internet) for the facility's marketing purposes. I also understand that the facility may hire third parties to capture the image and/or voice of the individual identified above, and that my information will be used and disclosed by these third parties as instructed by the facility.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if any videotape, photograph or audiotape references drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐ **Yes** ☐ **No** ____________ **Initials**

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Facility Privacy Official at: ______________

Unless revoked, this authorization will expire on the following date or event: ______________

In the event that facility has relied on this authorization to create marketing and/or other promotional materials featuring my likeness (e.g., photographs or video), audiotapes of my voice, my name, my testimonial or recommendation and/or other information released pursuant to this authorization, I understand and agree that facility shall retain the right to use my likeness, voice, name, testimonial and/or other information until such time as all such marketing and/or promotional materials then in existence at the time of any revocation of this authorization are distributed, disseminated or expire. Any revocation of this authorization will become effective only after all marketing and/or promotional materials are distributed, disseminated or expire.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

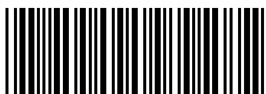
I understand that facility may not condition treatment, payment, enrollment, or eligibility for benefits for the individual identified above on whether I sign this authorization form. I may inspect or copy the protected health information to be used or disclosed. **I authorize the facility to use and disclose the protected health information specified above for the purposes set forth above.**

Signature: ______________ Print Name: ______________ Date: ________ Time: ________

Authority to Sign if not patient (e.g., parent, guardian): ______________

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify:** ______________

Verified by Facility Employee (Signature): ______________ Date: ________ Time: ________



Authorization for Use and Disclosure of Protected Health Information for Marketing and/or Promotional Purposes

TREAT
H10075 (10/14)

Patient Information/Label

*This Form to be used in conjunction with the Form entitled “Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes”.

For good and valuable consideration, receipt of which is hereby acknowledged, I authorize HCA-HealthONE LLC and its affiliates (collectively, “HealthONE”) and its respective parents, affiliates, subsidiaries, licensees, successors, and assigns to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish any verbal or written statements, testimonials or biographical information I may provide regarding HealthONE and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s) (collectively, the “Materials”). I understand that for purposes of this consent, the terms “image,” “voice” and “photograph” encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

HealthONE shall be the owner of the results and proceeds of such taping, photography, and recording with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet, all or any portion thereof or of a reproduction thereof, free of any payment, royalty, or other compensation of any kind to me. I expressly understand and agree that the Materials and all results and proceeds derived therefrom, shall be the sole and absolute property of HealthONE for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf. I further represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby represent and warrant that I have not given any other person, entity or firm the exclusive right to use my name, likeness, voice or photograph, and that by signing this document I am not in breach of any other agreement to which I am a party.

I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of HealthONE and that HealthONE is under no obligation to use the Materials. I acknowledge that HealthONE will rely on this permission potentially at substantial cost to HealthONEand hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby acknowledge that I am solely responsible for any statements made by me during the recording of my voice and/or likeness as described above, which statements shall consist solely of my opinions and do not necessarily represent those of HealthONE, which is not responsible for the content of such statements. I hereby forever release and discharge HealthONE, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither HealthONE nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above or in the execution of this Consent for Use and Disclosure of Image, Voice and/or Written Testimonials (the “Consent”).

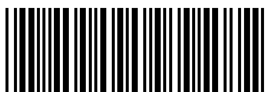
I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the “Authorization”), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: ______________________________

Print Name: ______________________________ Date: ______________ Time: ______________

Relationship of Legal Representative to Patient (e.g., parent, guardian): ______________________________

Patient Information/Label



Consent for Use and Disclosure of Image, Voice and/or Written Testimonials

TREAT
H10076 (10/14)