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3535 W. 13 Mile Rd. Suite 205
Royal Oak, Michigan 48073
Phone: 248-551-8180
Fax: 248-551-8181

Patient's Name:_____Appt. Date:_____

Birth Date:_____Age_____

Patient Gender Identity: Female____ Male____ Transgender female (male to female)____

Transgender male (female to male)____

Patient Sex Assigned at Birth: Female____ Male____

Marital Status: Single_____Married_____Widowed_____Divorced_____

Patient's Address:_____

_____

City State Zip

Home Phone Number:(_____)_____Cell:(_____)_____

Business Phone Number:(_____)_____

Patient's Social Security_____E-Mail_____

Race: African American_____Native American_____Asian_____Caucasian_____

Native Hawaiian/Pacific Islander_____Other_____

Ethnicity:_____Preferred Language:_____

Do you need an interpreter: Y N

Name of Spouse:_____Spouse Birth Date:_____

PATIENT'S Occupation:_____

Name of Employer:_____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. FURTHERMORE, I AUTHORIZE THIS OFFICE TO RELATE OUR EVALUATION TO OTHER PHYSICIANS PROVIDING CARE TO ME THAT WILL ENHANCE CONTINUITY OF CARE.

Patient or Guardian Signature_____**2024/2025 PAPERWORK**

Patient Name: _____ **Past Medical History (please circle response)**

Diabetes Y or N	**If yes, please answer questions below** **Insulin Y or N** **Neuropathy Y or N** **Retinopathy Y or N** **Diabetic pills Y or N** **Nephropathy Y or N**		
Hypoglycemia	Y or N	Hepatitis	Y or N
Hypertension	Y or N	Liver disease	Y or N
High cholesterol	Y or N	Psychiatric hospitalizations	Y or N
High triglycerides	Y or N	Seizures	Y or N
Cancer (list type)	Y or N	Headache (list type)	Y or N
Obstructive sleep apnea Snoring. C.Pap/BiPap	Y or N	COPD/emphysema	Y or N
Joint pain (circle areas) Low back, hip, knee, ankle, foot, hands, shoulder, other.	Y or N	Asthma	Y or N
Depression	Y or N	Kidney disease	Y or N
Heartburn/reflux	Y or N	Kidney stones	Y or N
Hiatal hernia	Y or N	Kidney failure on dialysis?	Y or N Y or N
Rheumatic fever	Y or N	Skin disorder	Y or N
Coronary Artery Disease (blockages/stents)	Y or N	Osteoporosis	Y or N
Abnormal heart structure (valve, congenital, etc.)	Y or N	Stroke TIA	Y or N Y or N
Heart attack	Y or N	Ulcers	Y or N
Heart failure (congestive/ischemic)	Y or N	TB	Y or N
Irregular heart rate (atrial fibrillation)	Y or N	Varicose veins	Y or N
Chest pain or angina	Y or N	Bowel disease (irritable bowel, colitis, ulcerative colitis, etc)	Y or N
Bladder incontinence	Y or N	Blood in stool	Y or N
Leg/ankle swelling	Y or N	Crohn's disease	Y or N
Blood clot or phlebitis (DVT)	Y or N	Glaucoma	Y or N
Pulmonary embolus (blood clot in lung)	Y or N	Difficult to place breathing tube	Y or N
Gallstones or gallbladder problems	Y or N	Home oxygen	Y or N
Shortness of breath with activity	Y or N	Anesthetic reaction	Y or N
Anemia	Y or N	Diarrhea	Y or N
Bleeding problem	Y or N	Constipation	Y or N
Gout	Y or N	Obesity	Y or N

Do you have any religious, culture or spiritual beliefs that would prevent you from receiving blood? Y or N

Please list any other medical conditions not listed above_____

Patient Name:_____

Previous Surgical Operations/Anesthetics

With respect to each and every operation which you have undergone, please provide the following information.

Operation	Date	Problems/Complications (if any)

Past Non-Surgical Hospitalizations

Please list all previous major non-surgical hospitalizations.

Problem	Date	Location/Hospital

****

PHARMACY NAME:_____

Address:_____

_____

Phone Number:_____Fax Number:_____

Patient Name:_____

Cardiac Procedure History:

Have you had a EKG?
If yes, when?_____

Have you had a STRESS TEST?
If yes, when?_____

have you had a CARDIAC CATHETERIZATION?
If yes, when?_____

Medication History

Please list current medications, **including dosage and frequency.**

Prescription Drugs

Name	Dose	Frequency

Over-the-Counter Medications/Vitamins

Patient Name:_____

Food Allergies

Have you ever had a reaction to any of the following:			If yes, please explain:
Milk/Dairy Products	Y	N	_____
Eggs	Y	N	_____
Shellfish	Y	N	_____

Medication Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If so, please provide the following information concerning each and every medication to which you are allergic.

Name of Medication	Type of Reaction

Are you allergic to Latex? ☐ Yes ☐ No
Are you allergic to Iodine Dye? ☐ Yes ☐ No

Patient Name:_____

Emergency Contact Information:

Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____

Name:_____Relationship:_____

Home Phone:_____Cell Phone:_____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician's Name:	
Address (if known)	
Telephone Number (if known)	
Hospital doctor is affiliated with:	

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name:	
Address (if known)	

ENDOCRINOLOGIST (if applies)

Endocrinologist's Name:	
Address (if known)	

Please list all other medical doctors with which you are currently being treated

PHYSICIAN NAME:	SPECIALTY:

Patient Name:_____

Family History: Has anyone in your family had any of the following? **If YES, please state which family member.**

			relationship
High blood pressure	Y	N	_____
High cholesterol	Y	N	_____
Heart disease	Y	N	_____
Stroke	Y	N	_____
Diabetes	Y	N	_____

Cancer (list types)

_____

_____

Bleeding disorders	Y	N	_____
Blood clots	Y	N	_____

WOMEN:

Are you currently pregnant? Y or N

Number of pregnancies:_____ Number of live births:_____

HISTORY OF FALLS:

Do you feel unsteady when walking?
Y N

Have you had 2 or more falls in the past 12 months?
Y N

If yes, how many falls in last year_____

Do you walk with an assistive device?
Y N

Patient Name:_____

ALCOHOL:

1. How often do you have a drink containing alcohol?
never monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
do not drink 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

3. How often do you have 6 or more drinks on one occasion?
never less than monthly monthly weekly daily or almost daily

TOBACCO:

Do you presently smoke tobacco? ☐ Yes ☐ No
If yes:
How many packs per day?_____

Have you ever smoked tobacco? ☐ Yes ☐ No
If yes:
How many packs per day?_____
For how many years?_____
When did you quit?_____

++

Do you presently use Snuff or Chew? ☐ Yes ☐ No

Have you ever used Snuff or Chew? ☐ Yes ☐ No, If yes, when did you quit?_____

++

E-CIGARETTES/VAPING HISTORY:

A. current every day B. current some day C. former user D. never user

If yes, how many cartridges/day?_____

If former use, when did you quit?_____

DRUG CONSUMPTION:

Do you currently use illicit drugs, including marijuana? ☐ Yes ☐ No

If yes, what type of drugs do you currently use?_____

How often do you use illicit drugs?_____

Have you ever used illicit drugs in the past? ☐ Yes ☐ No

PATIENT NAME:_____

Review of Systems. Please check all current symptoms

Currently, none of these symptoms apply to me _____

CONSTITUTIONAL
- Fever_____
- Chills _____
- Weight Loss_____
- Fatigue_____
- Sweats_____
- Weakness_____

SKIN
- Rash_____
- Itching_____
- Jaundice_____

HENT:
- Headaches_____
- Hearing loss_____
- Ringing in ears_____
- Ear pain_____
- Nosebleeds_____
- Congestion_____
- Sore throat_____

EYES:
- Blurred vision_____
- Double vision_____
- Photophobia_____

MUSCULOSKELETAL
- Myalgias_____
- Neck pain_____
- Back pain_____
- Joint pain_____
- Falls_____

NEUROLOGICAL
- Dizziness_____
- Tingling_____
- Tremor_____
- Sensory change_____
- Speech change_____
- Focal weakness_____
- Seizures_____

ALLERGY/IMMUNOLOGY
- Allergic reaction_____
- Recurrent infections_____

CARDIOVASCULAR
- Chest pain_____
- Palpitations_____
- Shortness of breath_____
- Claudication_____
- Leg swelling_____

RESPIRATORY:
- Cough_____
- Shortness of breath_____
- Wheezing_____

GASTROINTESTINAL
- Heartburn_____
- Nausea_____
- Vomiting_____
- Abdominal pain_____
- Diarrhea_____
- Constipation_____
- Blood in stool_____

GENITOURINARY
- Pain or burning_____
- Urgency_____
- Frequency_____
- Blood in urine_____

PSYCHIATRIC
- Depression_____
- Suicidal ideas_____
- Substance abuse_____
- Hallucinations_____
- Nervous/anxious_____
- Insomnia_____
- Memory loss_____

ENDOCRINE
- Appetite changes_____
- Cold intolerance_____
- Increased thirst_____
- Increased urination_____
- Hair changes_____

HEMATOLOGY
- Easy bruising_____
- Enlarged lymph nodes_____
- Prolonged bleeding_____

PLEASE COMPLETE THIS PAGE FRONT AND BACK ONLY IF YOU ARE HERE REGARDING BARIATRIC SURGERY. IF NOT, PLEASE DISREGARD.

Weight and Diet History

What is your height?_____ What is your current weight?_____ lbs.

What is your highest weight_____ lbs.

At what age did you develop a significant weight problem? _____

Approximate age when you first started dieting? _____

PREVIOUS DIET HISTORY

(Circle Y if you have attempted or N if you have not attempted)

Type of Diet	Attempted Y or N	Length of Time	Year Attempted
COMMERCIAL DIET PROGRAMS			
Weight Watchers	Y N		
Jenny Craig	Y N		
L.A. Weight Loss	Y N		
Overeaters Anonymous	Y N		
Medifast	Y N		
Nutrisystem	Y N		
HMR	Y N		
Optifast	Y N		
Slimfast	Y N		
PRESCRIPTION MEDICATIONS			
Redux (Dexfenfluramine)	Y N		
Pondimin (Fenfluramine)	Y N		
Fen-Phen (Fastin, Adipex)	Y N		
Amphetamines	Y N		
Meridia (Sibutramine)	Y N		
Glucophage	Y N		
Xenical (Orlistat)	Y N		
HERBAL AND DIET PILL REMEDIES			
Ephedra (Ma Huang)	Y N		
Metabolife	Y N		
Dexatrim	Y N		
Trimspa	Y N		

MEDICAL AND HEALTH CARE TREATMENTS	Attempted Y or N	Length of Time	Year Attempted
Previous gastric surgery	Y N		
Jaw wiring	Y N		
Dietician or Nutritionist	Y N		
Behavior Therapy	Y N		
Psychotherapy	Y N		
Exercise program	Y N		
SELF-INITIATED DIETS			
Atkins	Y N		
South Beach Diet	Y N		
Richard Simmons	Y N		
OTHER (list)			

Have you taken any aspirin products (Aspirin, Motrin, Aleve, etc.) within the last 7 days?

Y or N

I have carefully read all the materials in this assessment and have answered the questions as truthfully as possible. I understand that withholding or falsifying information may be dangerous to my medical care.

Patient Signature:_____Date_____

Dear Patient,

William Beaumont Hospital, Royal Oak has partnered with Michigan Hospitals to establish The Michigan Bariatric Surgery Collaborative (MBSC). The MBSC's goal is to study the effects and improve the quality of care for patients undergoing weight loss surgery.

We would like to invite you to participate in this study. Initially, you will be asked to read the (MBSC) pamphlet provided. Your surgeon will review the information about the study with you at your appointment.

You will then be asked to sign a consent form to participate and complete a baseline questionnaire. The MBSC will mail you a questionnaire at year one, two and three years after your surgery. Please complete the questionnaire and send them back in the postage paid envelopes. I would like to emphasize that no one will be calling your home to disturb you.

Participation in this study will allow hospitals and their health care teams to study the information you provide and make changes to improve the quality of care for weight loss surgery patients in the State of Michigan.

Thank you for your support.

*****WE WILL REVIEW THIS AT YOUR APPOINTMENT*****

COMPLETION OF THIS FORM ALLOWS ROYAL OAK SURGICAL ASSOCIATES TO SPEAK WITH PEOPLE LISTED IN #2.

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION WAIVER OF PRIVACY

The undersigned,_____

whose address is_____ states:

1. **Authorization.** You are authorized to do the following:

   a. Disclose any and all information regarding my past and current medical treatment and care;

   b. Provide copies of all documents and records in your possession regarding my medical condition and treatment, at any time, including medical history and findings, consultations, prescriptions, treatments, x-rays, radiology reports, special consultation reports, diagnosis and prognosis, copies of all hospital, medical and billing records.

2. **Provide Information To.** The information identified in this document may be released, provided to, or discussed with any of the following persons: _____

   _____

3. **When to Provide Information.** You are authorized to provide the information identified in this document at the request of the individual or individuals identified in paragraph 2 above.

4. **Expiration.** This Authorization contains no expiration date.

5. **Authority to Revoke.** The undersigned reserves the right to revoke this authorization. In order to revoke this authorization, the notification must be written, signed by the undersigned, and dated. The revocation will then become effective upon delivery to you.

6. **Redisclosure.** I understand that the information disclosed by reason of this document may be subject to re-disclosure by the recipient and therefore may no longer be protected under state or federal law.

7. **Photostatic Copies.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.

8. **Voluntary Action.** I understand that I am not required to sign this document and I am signing this document voluntarily.

9. **Privacy Waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation that might otherwise prevent any health care provider from providing access to my medical records under this document, and I hold harmless from any claim of liability under such act, rule or regulation, any medical provider who provides access to my medical information and records under this document.

10. **Durable Power**. This power of attorney shall not be affected by my disability. The authority of my agent shall be exercisable notwithstanding my later disability or incapacity or later uncertainty as to whether I am alive.

Dated: _____

_____
Signature

_____
Print Name

PREPARED BY FERGUSON & WIDMAYER, P.C.
538 North Division
Ann Arbor, Michigan 48104
734-662-0222

PLEASE COMPLETE NAME, ADDRESS, #2, DATE AND SIGN.
If you have a Durable Power of Attorney, please bring a copy with you to appointment.

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting [name or title of Privacy Officer].

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date Time
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

Last Update:____/____/____

PLEASE SIGN AND DATE
PLEASE OBTAIN A PRIVACY POLICY PACKET IN ROYAL OAK SURGICAL ASSOCIATES LOBBY.

ROYAL OAK SURGICAL ASSOCIATES, INC.
Beaumont Medical Building
3535 West 13 Mile Road, Suite 205
Royal Oak, Michigan 48073
Phone: (248) 551-8180 Fax: (248) 551-8181
Peter F. Czako, M.D., F.A.C.S.
Kevin R. Krause, M.D., F.A.C.S.
Sapna Nagar, M.D., F.A.C.S.
Kathryn M. Ziegler, M.D., F.A.C.S.

Patient Financial Policy

Royal Oak Surgical Associates PC, have implemented the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and treatment to you. Your understanding of your financial responsibilities is an essential element of your care and treatment.

PAYMENT OPTIONS: Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at the time of service for any copays, coinsurance, deductibles or previous balances. For your convenience we accept Cash, Check, Visa, Mastercard, Discover and American Express.

INSUFFICIENT FUNDS: If a check is returned by your financial institution for insufficient funds, we will charge your account an additional fee of $25.00

CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENT: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.**

YOUR INSURANCE: We have made prior arrangements with many insurance plans to accept an assignment of benefits. Your healthcare policy contract is between you and your insurance company which you or your employer has agreed upon. You may be required to pay for deductibles, copays, co-insurance, or cost share amounts.

If you are enrolled in a HMO and require a referral, you are responsible for providing that information. Failure to provide proper authorization will require the patient to reschedule their appointment or pay for services rendered.

In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

I consent to receive text messages: **Y** **N**

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor **Date**