

Welcome

A. JOSEPH CRIBBINS III, MD • KELI McCALMAN, DO, FACOS

6020 West Parker Road, Suite 430 • Plano, Texas 75093

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

BARIATRIC PATIENT FORM

PATIENT INFORMATION (PLEASE ENTER FULL LEGAL NAME)		
Last:	First:	Middle:
Preferred Name:		
Address:	City/State:	Zip Code:
Home Phone:	Mobile Phone:	Work Phone:
Email Address:	Employer:	Occupation:
Social Security:	DL#	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Widower		

PLEASE COMPLETE IF INSURANCE IS CARRIED BY SOMEONE OTHER THAN THE PATIENT		
Last Name:	First Name:	MI:
Date of Birth:	Home Phone:	Cell Phone:
Address:	City/State:	Zip Code:
SSN:	DL#	Relationship to Patient
Employer	Employer Address:	
Work Phone:	Occupation:	

EMERGENCY CONTACT		
Name:	Relationship:	Phone Number

INSURANCE INFORMATION	
Primary Insurance Company	Phone Number:
Policy / Certification #:	Group Account #:
Secondary Insurance Company	Phone Number:
Policy / Certification #:	Group Account #:

LIST ALL CURRENT PHYSICIANS		
Primary Care Physician:		Phone Number:
Physician:	Specialty:	Phone Number:
Physician:	Specialty:	Phone Number:
Physician:	Specialty:	Phone Number:

TELL US HOW YOU HEARD ABOUT OUR PRACTICE		
<input type="checkbox"/> Internet Search	<input type="checkbox"/> PCP/Referring Doctor (Name) _____	<input type="checkbox"/> Our Website
<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Relative or Friend (Name) _____	<input type="checkbox"/> Baylor Hospital Website
<input type="checkbox"/> Social Media / FB	<input type="checkbox"/> Current Patient (Name) _____	<input type="checkbox"/> Texas Health Hospital Website

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

 _____
Signature

Printed Name

Date (MM/DD/YY)

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Weight: _____ Height: _____ Years Overweight _____ Date of Birth: _____ Age: _____

What brought you to the office today? _____

PHARMACY INFORMATION		
Pharmacy:	Phone Number:	Fax Number:

LIST ALL ALLERGIES	REACTIONS

MEDICATIONS: (please list all medications you are currently taking)

NAME	DOSAGE	FREQUENCY	INDICATION

OFFICE USE

VITAMIN SUPPLEMENTS: (Please check all that apply)

- Multi-Vitamin
 Iron
 Calcium
 Vitamin B12
 Vitamin D
 Other _____

LIST ALL PREVIOUS SURGERIES

PROCEDURE	YEAR	SURGEON

FAMILY HISTORY: (please indicate family members having any of the following illness with an "X")								
	MOTHER	FATHER	MATERNAL GRAND MOTHER	MATERNAL GRAND FATHER	PATERNAL GRAND MOTHER	PATERNAL GRAND FATHER	SIBLINGS	CHILDREN
OBESITY								
DIABETES								
HIGH BLOOD PRESSURE								
HEART DISEASE								
CANCER								
SEIZURES								
BREATHING PROBLEMS								
KIDNEY DISEASE								
ARTHRITIS								
EARLY DEATH & CAUSE								
OTHER								

SOCIAL HISTORY: (Please <input checked="" type="checkbox"/> check all that apply)		
<input type="checkbox"/> Do you currently smoke/vape?	<input type="checkbox"/> Have you ever smoked/vaped?	Year Quit:
<input type="checkbox"/> Do you use alcohol?	If Yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely	
<input type="checkbox"/> Have you ever had a problem with substance abuse / Recreational Drugs?		
<input type="checkbox"/> Have you ever been treated for depression?		
<input type="checkbox"/> Are you currently in treatment? If Yes, Name of Therapist:		
<input type="checkbox"/> Have you ever been hospitalized for mental illness? If Yes, Where:		

RECENT TESTING: (Please <input checked="" type="checkbox"/> check all that apply and list any others)			
<input type="checkbox"/> Physical	Date:	<input type="checkbox"/> Upper GI	Date:
<input type="checkbox"/> Chest X-Ray	Date:	<input type="checkbox"/> EKG	Date:
<input type="checkbox"/> Echocardiogram	Date:	<input type="checkbox"/> Labs	Date:
<input type="checkbox"/>	Date:	<input type="checkbox"/>	Date:

SYSTEM REVIEW: (Please check all that apply)

Constitutional

- Fatigue
- Tiredness
- Recent weight loss
- Fever
- Night sweats
- Abnormal bleeding

Respiratory

- Shortness of breath
- Asthma
- Wheezing
- Cough
- Bloody sputum
- Emphysema
- Pneumonia
- Bronchitis
- Difficulty sleeping flat
- Waking up short of breath

Cardiovascular

- Chest pain
- Pain in arms and neck
- Heart attack
- Palpitations
- Heart pounding
- Abnormal heart beats
- Heart murmur
- Stroke
- High/low blood pressure
- Pain in legs
- Cold feet
- Loss of pulses

Endocrine

- Hyper/hypothyroid
- Goiter
- Previous radiation
- Diabetes
- Adrenal gland tumor
- Previous steroid use
- Swollen glands

Musculoskeletal

- Pain in joints
- Muscular aches
- Swelling in joints
- Arthritis
- Pain in hips, knees, ankles or feet
- Low back pain
- Herniated disk
- Sciatica
- Numbness in feet or legs
- Abnormal lumps or masses

Genitourinary

- Blood in urine
- Frequent urination
- Leakage of urine
- Pain with urination
- Trouble starting urine
- Kidney stone
- Bladder infection

Men

- Discharge from penis
- Loss of erection

Neurological

- Seizures
- Convulsions
- Fainting
- Dizziness
- Light headedness
- Falling
- Muscle weakness
- Numbness
- Tremors
- Loss of consciousness
- Strokes

Psychological

- Depression
- Nervousness
- Anxiety
- Suicidal thoughts
- Suicide attempts
- Schizophrenia
- Anorexia
- Bulimia
- Binge eating
- Hospitalization for emotional problems
- Psychiatric or psychological counseling

Head and Neck

- Blurred vision
- Double vision
- Loss of vision
- Dizziness
- Vertigo
- Sinus congestion
- Runny nose
- Sneezing
- Loss of smell
- Sinus infection
- Sore throat
- Difficulty swallowing
- Pain when swallowing
- Hoarseness
- Lump in neck

Gastrointestinal

- Jaundice
- Hepatitis
- Cirrhosis
- Vomiting
- Nausea
- Heartburn
- Abdominal pain
- Diarrhea
- Constipation
- Pain with bowels
- Blood in stool
- Hemorrhoids
- Change in stool size
- Colitis
- Fatty Liver

Women

- Vaginal discharge
- Abnormal vaginal bleeding
- Irregular periods
- Pelvic/pap exam within the last year
- Hysterectomy

Skin/Breast

- Skin cancer
- Abnormal moles
- Burns
- Rash
- Breast mass
- Nipple discharge
- Mammogram with in the last year
- MRSA

OBESITY RELATED MEDICAL HISTORY: (Please <input checked="" type="checkbox"/> check all that apply)					
Problem/Symptom	Year	Physician	Problem/Symptom	Year	Physician
<input type="checkbox"/> Heart Disease			<input type="checkbox"/> Umbilical Hernia		
<input type="checkbox"/> Angina			Number of hernia repairs _____		
<input type="checkbox"/> MI (Heart Attack)			<input type="checkbox"/> Venous Stasis		
<input type="checkbox"/> Coronary Bypass Surgery			<input type="checkbox"/> Leg or ankle edema		
<input type="checkbox"/> Palpitations			<input type="checkbox"/> Leg Ulceration		
<input type="checkbox"/> Congestive Heart Failure			<input type="checkbox"/> Pain Of Arthritis		
<input type="checkbox"/> High Blood Pressure			<input type="checkbox"/> In ankles		
<input type="checkbox"/> Elevated Cholesterol			<input type="checkbox"/> In knees		
<input type="checkbox"/> Elevated Triglycerides			<input type="checkbox"/> In hips		
<input type="checkbox"/> Asthma			<input type="checkbox"/> Limits ability to walk		
<input type="checkbox"/> Reflux			<input type="checkbox"/> Limits ability to exercise		
<input type="checkbox"/> Heartburn			<input type="checkbox"/> Low back pain/Sciatica		
<input type="checkbox"/> Esophagitis			<input type="checkbox"/> Limits ability to walk		
<input type="checkbox"/> Hiatal Hernia			<input type="checkbox"/> Limits ability to exercise		
<input type="checkbox"/> Shortness of Breath			<input type="checkbox"/> Diabetes		
I can walk ____ block(s)			<input type="checkbox"/> Juvenile onset		
I can climb _____ of stairs			<input type="checkbox"/> Gestational (pregnancy)		
<input type="checkbox"/> Sleep Apnea			<input type="checkbox"/> Adult Onset		
<input type="checkbox"/> Do you use CPAP/BiPAP?			<input type="checkbox"/> Diet controlled		
<input type="checkbox"/> Snoring			<input type="checkbox"/> Oral Medications		
<input type="checkbox"/> Awakening at night			<input type="checkbox"/> Insulin		
<input type="checkbox"/> Daytime Drowsiness			<input type="checkbox"/> Urinary Incontinence		
<input type="checkbox"/> Observed Apnea spells			<input type="checkbox"/> Leaking urine w/cough		
<input type="checkbox"/> Morning headaches			<input type="checkbox"/> Leaking urine w/sneeze		
<input type="checkbox"/> Migraine			<input type="checkbox"/> Leaking urine w/strain		
Frequency _____			Have you ever had:		
<input type="checkbox"/> Deep Venous Thrombosis			<input type="checkbox"/> Blood transfusion		
<input type="checkbox"/> Pulmonary embolism			<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> Abdominal wall hernia			<input type="checkbox"/> Exposed to HIV/AIDS		
<input type="checkbox"/> Incisional Hernia			<input type="checkbox"/> Abused IV drugs		

Have you ever been treated for an eating disorder? If Yes, please describe treatment, duration, and year: _____

PLEASE SELECT THE SURGERY YOU ARE INTERESTED IN:

Gastric Bypass Sleeve Gastrectomy Revision Lap-Band™

PREVIOUS WEIGHT LOSS SURGERY: (Please complete if you are seeking revision surgery)

Procedure	Date	Surgeon	Weight Loss
<input type="checkbox"/> Lap_Band			
<input type="checkbox"/> Gastric Bypass			
<input type="checkbox"/> Stapling (VBG)			
<input type="checkbox"/> Gastric Sleeve			
<input type="checkbox"/> Baloon			
<input type="checkbox"/>			
<input type="checkbox"/>			

Present complications due to previous weight loss surgery:

Weight prior to previous weight loss surgery:

Reason you are in need of a revision weight loss surgery:

MEDICALLY SUPERVISED WEIGHT LOSS TREATMENTS: (Please check all that apply)

<input type="checkbox"/> Belviq	Year:	Physician:
<input type="checkbox"/> Phentermine	Year:	Physician:
<input type="checkbox"/> Redux	Year:	Physician:
<input type="checkbox"/> Xenical (Orlistat)	Year:	Physician:
<input type="checkbox"/> Meridia	Year:	Physician:
<input type="checkbox"/> Fen-Phen	Year:	Physician:
<input type="checkbox"/> Other	Year:	Physician:

OTHER WEIGHT LOSS TREATMENTS: (Please check all that apply)

<input type="checkbox"/> Weight Watchers	Year:	<input type="checkbox"/> Herbalife	Year:
<input type="checkbox"/> Slim Fast	Year:	<input type="checkbox"/> Jenny Craig	Year:
<input type="checkbox"/> Medifast	Year:	<input type="checkbox"/> South Beach	Year:
<input type="checkbox"/> Nutrisystem	Year:	<input type="checkbox"/> Metabolite	Year:
<input type="checkbox"/> Atkins Diet	Year:	<input type="checkbox"/> Exercise	Year:
<input type="checkbox"/> Hypnosis	Year:	<input type="checkbox"/> Behavior Modification	Year:
<input type="checkbox"/> Acupuncture	Year:	<input type="checkbox"/> Liquid Diets	Year:
<input type="checkbox"/> Other:	Year:	<input type="checkbox"/>	Year:

Maximum weight lost on **ANY** program:

Please list all other medical conditions, illnesses or important information not previously mentioned.



Patient Signature

The above is true, correct, and complete to the best of my belief.

Date (MM/DD/YY)

Medical information has been reviewed by:

Physician Signature

Date (MM/DD/YY)

A. JOSEPH CRIBBINS III, MD • KELI McCALMAN, DO, FACOS
6020 West Parker Road, Suite 430 • Plano, Texas 75093

In our efforts to comply with the **HIPPA** (Health Information Privacy Act, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please check yes or no to the following questions.


- May we leave messages on a voicemail at work? Yes No
- May we leave messages on voicemail at home? Yes No
- May we leave messages on mobile voicemail? Yes No
- May we leave information with a spouse or significant other? Yes No
- Is there anyone that is not listed above that we can give information to? Yes No
- If yes, please specify - _____
- For any children above 18, still living at home, may we discuss your appointments and/or treatments with your parent(s) or guardian? Yes No
- I would like to receive regular email updates and/or newsletters. Yes No

You must inform us, in writing, of any changes in your directives. This record takes effect September 1, 2003 and will be kept in your file with your acknowledgement of receipt of our Notice of Privacy Practices.

 _____ Signature _____ Printed Name _____ Date (MM/DD/YY)

Notice of Physician Ownership

Dr. A. Joseph Cribbins III, MD and Dr. Keli McCalman, DO, FACOS have ownership interest in Baylor Scott & White Medical Center-Frisco, Texas. Dr. A. Joseph Cribbins III, MD has an ownership interest in Texas Health Center for Diagnostics & Surgery-Plano, Texas. I understand that my physician may refer me to one of these facilities for surgery. I also understand that I may speak with my physician about his or her financial relationship with the facility, and that I may ask my physician to provide my treatment at a facility where he or she has no ownership interest.

 _____ Signature _____ Printed Name _____ Date (MM/DD/YY)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.


This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.

 _____
Signature

Printed Name

Date (MM/DD/YY)

A. JOSEPH CRIBBINS III, MD • KELI McCALMAN, DO, FACOS

6020 West Parker Road, Suite 430 • Plano, Texas 75093s

We would like to thank you for making an appointment with our office. It is important that you understand the procedures of our office regarding Surgery.

- You are responsible for getting referrals and keeping them updated with our office. All records request from other physician's records, and any other records required for the approval process.
- You must pay any copays, deductibles or deposits at your pre-operative appointment at our office prior to your surgery. We do not offer payment arrangements.

Please read carefully & sign acknowledgment.

- I hereby authorize A. JOSEPH CRIBBINS III, MD / KELI McCALMAN, DO, FACOS to furnish medical records &/or test results including HIV status, via fax or mail, to my referring doctor, insurance companies and to the doctor to whom I am referred concerning my illness or treatment. I will not hold A. JOSEPH CRIBBINS III, MD/ KELI McCALMAN, DO, FACOS or its employees responsible for any misdirected records or correspondence. I authorize payment of all medical benefits to A. JOSEPH CRIBBINS III, MD/ KELI McCALMAN, DO, FACOS
- An assistant surgeon or PA may be assisting with your surgery. The assistant surgeon might be out of network with all insurance companies.
- The office staff will notify you if there will be a deposit due for the assistant. If your insurance company pays the assistant surgeon's fee, the deposit will be refunded back to you. If your insurance company does not pay, we will keep the deposit and accept that as payment in full for the assistant surgeon. Refunds are given according to office policy and after all deductible, copays, co-insurance and claims have been paid. This amount is not included in out of pocket maximums.
- There is a \$25.00 fee for completing Family Medical Leave or disability papers each time they are requested.
- I hereby certify that I have provided A. JOSEPH CRIBBINS, MD / KELI McCALMAN, DO, FACOS my current Insurance, address, phone numbers, and any other pertinent information. I also understand that failing to disclose this information could result in my insurance carrier not providing benefits for this service.

TO ALL PATIENTS: If for any reason you decide to cancel your surgery, please inform us at least 48 hours in advance to avoid a \$250.00 cancellation fee.



Signature

Printed Name

Date (MM/DD/YY)