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Patient Information Form - 1

Please complete these questions:

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Patient's SSN: _____ Patient's Employer: _____

E-mail address : _____

Spouse's Name: _____

Spouse's Employer: _____

Spouse's SSN: _____ Work phone: _____

Primary Care Physician: _____ Phone: _____

Nearest Relative: _____ Phone: _____

Friend not living with you: _____ Phone: _____

IN CASE OF AN EMERGENCY

Whom may we contact: _____ Phone: _____

Insurance Company: _____ Co-Pay: _____

Friends/relatives that we can release medical information: _____

If patient is minor parent/guardian must fill out below:

Parent/Guardian Name: _____

Parent Address: _____

City: _____ State: _____ Zip: _____

Parent Phone: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Parent SSN: _____ Spouse's Name: _____

Continue...

Patient Information Form - 2

Please read and sign below:

I understand and agree that (regardless of my Insurance Status) I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorized Dr. Wilkenfeld or his staff to release any information acquired in the course of any exam or treatment to my physician (s) and / or Insurance Companies. I hereby authorize payment directly to Dr. Wilkenfeld for any services rendered. A copy of this is as legal as the original.

Signature of Patient / Guardian

Date

Please read and Initial:

Office Visits:

Payment is due at the time of services except for MEDICARE, MEDICAID, PUBLIC ASSISTANCE, PPO'S and HMO'S. If you have an HMO or PUBLIC ASSISTANCE it is your responsibility to bring your referral with you from your PCP. If you do not bring the referral with you, you will have to pay for the visit or reschedule your appointment. **It is not our responsibility to get your referrals for you.** _____

Surgeries:

We will call your Insurance Company to verify coverage and pre-certify your surgery. Out of courtesy we will file your surgery charges for you. You will be responsible for your deductible and the percentage that is not covered by the Insurance Company. **This amount will be collected before your surgery.** _____

Other Charges:

Our bill is for the surgeon's fee only. You will also receive bills from anesthesiology, pathology, radio - logy, laboratory, the hospital or surgery center, and sometimes an assistant surgeon. _____

NOTE: Insurance Companies set fees that are below our customary charges. Our charges are equal for everyone, but not all Insurance Companies pay the same rate for the same procedure. Any problem with the Insurance Company regarding the "reasonable and customary" fees are between the patient and the Insurance Company. We do not make adjustments on the balance unless we are a Provider for the Insurance Company. If we are a Provider, we have signed a contract agreeing to accept the amount allowed. Whatever an HMO or PPO allows, we do write off the difference and bill the patient for the amount approved, but not paid by the Insurance Company.

We accept assignment on MEDICARE patients, but MEDICARE patients who do not have a secondary insurance are responsible for the 20% that MEDICARE approves but does not pay. The patient is also responsible for any deductible not met.

If you have any question about our policy, we will be glad to assist you.
We accept cash, checks (post dated checks), Mastercard, Visa, Discover.

Please initial here that you have read and understand the above statement. _____

Patient Medical and Weigh Loss History - 1

Patient Name: _____

Allergies to Medications: _____

Primary Care Physician: _____ Phone: _____

Medications (please list all medications you are currently taking)

Name of Medication	Dosage	Frequency	Indication

Past Surgical History (please list all surgical procedures and operations)

Procedure	Date	Location	Indication

Family History (please indicate family members diagnosed with the following illnesses)

Illness	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Seizures								
Asthma								
Arthritis								
Kidney Disease								
Early Death								

Patient Medical and Weigh Loss History - 2

Patient Name: _____

How many years have you been overweight?: _____

Previous Weight Loss Surgery NO _____ YES _____ (please indicate bellow)

Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate witch of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri-System				
Optifast				
Pritikin Diet				
Slim Fast				
TOPS				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate witch of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexafenaflouramine)				
Xenical (Orlistat)				
Meridia (Siburtramine)				
Other Diet Medication				

Continue...

Patient Medical and Weigh Loss History - 3

Patient Name: _____

Non-Dietary Therapies (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				
Other				

Comments: _____

Patient Social History - 1

Patient Name: _____

Do you use Tobacco?	YES: _____	NO: _____
Number of packs per day?	_____	
Number of years smoking?	YES: _____	NO: _____
Do you use Alcohol?	YES: _____	NO: _____
Amount and frequency:	_____	
Have you ever been treated for depression?	YES: _____	NO: _____
Are you currently in treatment?	YES: _____	NO: _____
If yes, please indicate the name and phone number of your physician or therapist:		

Have you ever been hospitalized for mental illness:	YES: _____	NO: _____

System Review (Please circle all that apply)

Constitutional:

Fatigue
Tiredness
Recent Weigh Loss
Fever
Night Sweats
Abdominal Bleeding

Head and Neck:

Blurred Vision
Double Vision
Loss of Vision
Loss of Hearing
Vertigo
Sinus Congestion
Sinus Infection
Runny Nose
Sneezing
Loss of Smell
Sore Throat
Difficulty Swallowing
Pain Swallowing
Hoarseness
Lump in Neck

Cardiovascular:

Chest Pain
Pain in Arm/Neck
Heart Attack
Palpitations
Heart Pounding
Stroke
Heard Murmur
Pain in Legs
Cold Feet
Loss of Pulses
Low Blood Pressure
High Blood Pressure
Abnormal Heartbeat

Respiratory:

Shortness of Breath
Asthma
Wheezing
Coughing
Bloody Sputum
Emphysema
Pneumonia
Bronchitis

Difficulty Sleeping Flat
Waking at Night

Gastrointestinal:

Jaundice
Hepatitis
Cirrhosis
Vomiting
Nausea
Heartburn
Abdominal Pain
Diarrhea
Constipation
Painful Bowel Movements
Blood in Stool
Hemorrhoids
Change in Stool Size
Irritable Bowel
Colitis

Genitourinary:

Blood in Urine
Frequent Urination
Leakage of Urine

Painful Urination
Trouble Starting Urine
Kidney Stones
Bladder Infection

Musculoskeletal:

Painful Joints
Swelling of Joins
Muscle Aches
Arthritis
Pain in Hips
Pain in Ankles
Pain in Feet
Low Back Pain
Herniated Disk
Sciatica
Numbness of Legs/Feet
Abnormal Lumps/Masses

Continue...

Patient Social History - 2

Patient Name: _____

System Review continuation...

Neurological:

Seizures
Convulsions Fainting
Vertigo
Light Headedness
Falling
Muscle Weakness
Numbness
Tremors
Loss of Consciousness

Psychological:

Depression
Nervousness
Anxiety
Suicidal Thoughts
Suicide Attempts
Schizophrenia
Anorexia
Bulimia
Binge Eating
Hospitalization

Endocrine:

Hyperthyroid
Hypothyroid
Goiter
Previous Radiation
Diabetes
Adrenal Tumors
Previous Steroid Use
Swollen Glands

Skin / Breast:

Skin Cancer
Abnormal Moles
Burns
Rash
Breath Mass
Nipple Discharge
Mammogram Within Year

Men:

Discharge for Penis
Loss of Erection

Women:

Vaginal Discharge
Abnormal Bleeding
Irregular Periods
Hysterectomy
Pap Exam Within Year

Patient Obesity Related Medical History - 1

Patient Name: _____

Do you have, or have you ever had, any of the following illness or symptoms?

Heart Disease	YES: ____	NO: ____	Year of Diagnosis: _____
Angina	YES: ____	NO: ____	Year of Diagnosis: _____
In Knees	YES: ____	NO: ____	Year of Diagnosis: _____
MI (Heart Attack)	YES: ____	NO: ____	Year of Diagnosis: _____
Coronary Bypass Surgery	YES: ____	NO: ____	Year of Diagnosis: _____
Palpitations (Abnormal Heartbeat)	YES: ____	NO: ____	Year of Diagnosis: _____
Congestive Heart Failure	YES: ____	NO: ____	Year of Diagnosis: _____
High Blood Pressure	YES: ____	NO: ____	Year of Diagnosis: _____
Elevated Triglycerides	YES: ____	NO: ____	Year of Diagnosis: _____
Asthma	YES: ____	NO: ____	Year of Diagnosis: _____
Reflux	YES: ____	NO: ____	
Diet Controlled	YES: ____	NO: ____	Year of Diagnosis: _____
Heartburn	YES: ____	NO: ____	Year of Diagnosis: _____
Esophagitis	YES: ____	NO: ____	Year of Diagnosis: _____
Hiatal Hernia	YES: ____	NO: ____	Year of Diagnosis: _____
Sleep Apnea	YES: ____	NO: ____	Year of Diagnosis: _____

Do you use a CPAP / BiPAP Machine?	YES: ____	NO: ____	
Shortness Breath	YES: ____	NO: ____	
You can walk: _____			blocks
You can Climb: _____			flights of stairs
Snoring	YES: ____	NO: ____	
Awakening at Night	YES: ____	NO: ____	
Daytime Drowsiness	YES: ____	NO: ____	
Observed Apnea Episodes	YES: ____	NO: ____	
Morning Headaches	YES: ____	NO: ____	
Venous Stasis	YES: ____	NO: ____	
Leg or Ankle Edema	YES: ____	NO: ____	
Leg Ulceration	YES: ____	NO: ____	
Pain of Arthritis	YES: ____	NO: ____	
In Ankles	YES: ____	NO: ____	
In Knees	YES: ____	NO: ____	
In Hips	YES: ____	NO: ____	
Limits Ability to Walk	YES: ____	NO: ____	
Limits Ability to Exercise	YES: ____	NO: ____	
Low Back Pain / Sciatica	YES: ____	NO: ____	

Continue...

Patient Obesity Related Medical History - 2

Patient Name: _____

Continuation...

Diabetes	YES: ____	NO: ____	Year of Diagnosis: _____
Juvenile Onset	YES: ____	NO: ____	Year of Diagnosis: _____
Gestational (Pregnancy)	YES: ____	NO: ____	Year of Diagnosis: _____
Adult Onset	YES: ____	NO: ____	Year of Diagnosis: _____
Diet Controlled	YES: ____	NO: ____	
Oral Medications	YES: ____	NO: ____	
Insulin Dependent	YES: ____	NO: ____	

Urinary Incontinence	YES: ____	NO: ____	Year of Diagnosis: _____
Leaking Urine with Coughing	YES: ____	NO: ____	
Leaking Urine with Sneezing	YES: ____	NO: ____	
Leaking Urine with Straining	YES: ____	NO: ____	

Migraine	YES: ____	NO: ____	Year of Diagnosis: _____
Frequency:	_____		

Deep Venous Thrombosis	YES: ____	NO: ____	Year of Diagnosis: _____
Pulmonary Embolism	YES: ____	NO: ____	Year of Diagnosis: _____
Abdominal Wall Hernia	YES: ____	NO: ____	Year of Diagnosis: _____
Incisional	YES: ____	NO: ____	
Umbilical	YES: ____	NO: ____	
Number of hernia Repairs	_____		

Have you ever had:

Blood Transfusion	YES: ____	NO: ____	Year of Transfusion: _____
Hepatitis	YES: ____	NO: ____	Year of Diagnosis: _____
Exposure to HIV / AIDS	YES: ____	NO: ____	Year of Exposure: _____
Abused Intravenous Drug	YES: ____	NO: ____	

Past Medical History: Please list all other medical conditions, illness, or other important information not previously mentioned

Patient Signature

Date



Dr. Richard Wilkenfeld
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Insurance verification for Lap Band®
Procedure (CPT) Code 43770
Diagnosis Code 278.01

Call your Insurance company to complete these questions prior to your appointment.
Please bring this completed form to your appointment.

Patient Name: _____
Date of Birth: _____ SSN: _____
Insurance Company: _____ Phone: _____
ID Number: _____ Group Number: _____
Date Verified: _____ Spoke To: _____

Ask the person you speak to the following questions:

What is my effective date? _____
What type of plan do I have? _____
Do I need a referral to see a specialist? _____
What is my co-pay for a specialist? _____
What is my in-network deductible? _____
How much have I met of my in-network deductible? _____
After my deductible what percentage does my insurance pay? _____
What is my out of pocket? _____
How much of my out of pocket has been met? _____
Is there an exclusion on my policy for bariatric or weight loss surgery? _____
Do I have out of network benefits for bariatric procedures? _____
Is there a lifetime maximum for bariatric procedures? _____
What is the fax number for pre-determination? _____