Welcome TEXAS CENTER
FOR BARIATRICS & ADVANCED SURGERY

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: ❑ Male ❑ Female	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ 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

❑ Internet Search ❑ PCP/Referring Doctor (Name) _____ ❑ Our Website
❑ Insurance Company ❑ Relative or Friend (Name) _____ ❑ Baylor Hospital Website
❑ Social Media / FB ❑ Current Patient (Name) _____ ❑ 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 ☑ check all that apply)

❑ Do you currently smoke/vape? ❑ Have you ever smoked/vaped? Year Quit:

❑ Do you use alcohol? If Yes, how often? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Rarely

❑ Have you ever had a problem with substance abuse / Recreational Drugs?

❑ Have you ever been treated for depression?

❑ Are you currently in treatment? If Yes, Name of Therapist:

❑ Have you ever been hospitalized for mental illness? If Yes, Where:

RECENT TESTING: (Please ☑ check all that apply and list any others)

❑ Physical	Date:	❑ Upper GI	Date:
❑ Chest X-Ray	Date:	❑ EKG	Date:
❑ Echocardiogram	Date:	❑ Labs	Date:
❑ Covid-19 Positive or Negative	Date:	❑	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 ☑ check all that apply)					
Problem/Symptom	**Year**	**Physician**	**Problem/Symptom**	**Year**	**Physician**
❑ Heart Disease			❑ Umbilical Hernia		
❑ Angina			Number of hernia repairs _____		
❑ MI (Heart Attack)			❑ Venous Stasis		
❑ Coronary Bypass Surgery			❑ Leg or ankle edema		
❑ Palpitations			❑ Leg Ulceration		
❑ Congestive Heart Failure			❑ Pain 0f Arthritis		
❑ High Blood Pressure			❑ In ankles		
❑ Elevated Cholesterol			❑ In knees		
❑ Elevated Triglycerides			❑ In hips		
❑ Asthma			❑ Limits ability to walk		
❑ Reflux			❑ Limits ability to exercise		
❑ Heartburn			❑ Low back pain/Sciatica		
❑ Esophagitis			❑ Limits ability to walk		
❑ Hiatel Hernia			❑ Limits ability to exercise		
❑ Shortness of Breath			❑ Diabetes		
I can walk ____ block(s)			❑ Juvenile onset		
I can climb _____ of stairs			❑ Gestational (pregnancy)		
❑ Sleep Apnea			❑ Adult Onset		
❑ Do you use CPAP/BiPAP?			❑ Diet controlled		
❑ Snoring			❑ Oral Medications		
❑ Awakening at night			❑ Insulin		
❑ Daytime Drowsiness			❑ Urinary Incontinence		
❑ Observed Apnea spells			❑ Leaking urine w/cough		
❑ Morning headaches			❑ Leaking urine w/sneeze		
❑ Migraine			❑ Leaking urine w/strain		
Frequency _____			**Have you ever had:**		
❑ Deep Venous Thrombosis			❑ Blood transfusion		
❑ Pulmonary embolism			❑ Hepatitis		
❑ Abdominal wall hernia			❑ Exposed to HIV/AIDS		
❑ Incisional Hernia			❑ 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
❑ Lap_Band			
❑ Gastric Bypass			
❑ Stapling (VBG)			
❑ Gastric Sleeve			
❑ Baloon			
❑			
❑			

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)

❑ Belviq	Year:	Physician:
❑ Phentermine	Year:	Physician:
❑ Redux	Year:	Physician:
❑ Xenical (Ortistat)	Year:	Physician:
❑ Meridia	Year:	Physician:
❑ Fen-Phen	Year:	Physician:
❑ Other	Year:	Physician:

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

❑ Weight Watchers	Year:	❑ Herbalife	Year:
❑ Slim Fast	Year:	❑ Jenny Craig	Year:
❑ Medifast	Year:	❑ South Beach	Year:
❑ Nutrisystem	Year:	❑ Metabolite	Year:
❑ Atkins Diet	Year:	❑ Exercise	Year:
❑ Hypnosis	Year:	❑ Behavior Modification	Year:
❑ Acupuncture	Year:	❑ Liquid Diets	Year:
❑ Other:	Year:	❑	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
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 or text?	❑ 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 has an ownership interest in Baylor Scott & White Medical Center Frisco. 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)

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

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
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 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 or its employees responsible for any misdirected records or correspondence. I authorize payment of all medical benefits to A. JOSEPH CRIBBINS III, MD
- 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 III, MD 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)