North Carolina Surgery

PATIENT IDENTIFICATION

Patient's Legal Name ____

(LAST) (FIRST) (MIDDLE)

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Gender ____ Last 4 numbers Social Security# (some insurances require full SS) ________________

Birth Date ____________________

PATIENT INFORMATION: Race__________Hispanic_____Non-Hispanic________Language________________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ______________

Home Phone # __________________Mobile Phone #____________________Email Address______________

Referring Physician ____

Primary Care Physician____

Other Physicians to Whom You Want Communication Sent ________ ______________________

PATIENT EMPLOYMENT INFORMATION

Status: Full-time ____ Part-time ____ Retired ____ Retirement Date _________ Full Time Student? Y/N Other________

Employer's Name ______________________________ Phone # ____________________

GUARANTOR INFORMATION (Person Financially Responsible if different than patient)

Name of Guarantor ____________________________ Relationship to Patient ______________

Last 4 Digits of Social Security # ____________ Gender ________ Birth Date ________________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ______________

Home Phone # ____________________ Employer's Name ______________________

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact ____________________________ Relation to Patient ______________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ______________

Home Phone # __________________Work Phone # ________________Cell Phone # ______________

PRIMARY INSURANCE

Name of Insurance Company ____

Policyholder's Name **(if other than patient)**__________________________ Relationship____________

Birth Date ______________ Gender _________

SECONDARY INSURANCE

Name of Insurance Company ____

Policyholder's Name **(if other than patient)**__________________________ Relationship____________

Birth Date ______________ Gender _________

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) __________________ Description________________________

Accident Date and Time ________________Place of Accident (City,County,State)________________

Patient/Authorized Representative Signature ______________________________Date______________

UNC HEALTH CARE

Patient Name________________________

Date of Birth________________________

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care..[1] I understand that I am not required to complete this form in order to obtain health care.

Name: ______________________________ Phone Number: ______________________________

Relationship: ______________________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: ______________________________ Phone Number: ______________________________

Relationship: ______________________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

____DATE: ________________ TIME:__________

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): ____

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

HDF5338 06/09/17

Chart Location: Consents

UNC HEALTH®

Patient Label Here

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a "UNC Health affiliate" or collectively as "UNC Health affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate. and who provide services to the UNC Health affiliates' patients in accordance with their professional judgment. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health's *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for

Patient Label Here

payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, or their agents or representatives, may contact me by electronic mail or telephone (including phone calls or text messages) at any electronic mail address or number contained in my UNC Health affiliate's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone, or electronic mail to determine my interest in participating in human subject research. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke consent to receive communications via phone calls, text messages or electronic mail at any time by following the instructions in the communication or calling UNC Health Customer Service at (888) 996-2767.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

____ DATE: _____________ TIME: _____________
PATIENT SIGNATURE (or Authorized Representative)

____
PRINTED NAME

RELATIONSHIP, if not patient: ____

GUARANTOR OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

____ DATE: _____________ TIME: _____________
GUARANTOR OF PAYMENT SIGNATURE

____
PRINTED NAME

Rex Bariatric Specialists

Appointment Date:	
Name:	DOB:
Referring Physician:	Office Phone Number:
Primary Care Physician:	Office Phone Number:
Decision Maker in the Event of an Emergency:	
Decision Maker's Phone Number:	

Allergy: Please list all allergies and reactions	**Reaction**

Pharmacy Name	**Pharmacy Address**

Current Medications:

Medication name	**Dosage**	**Amount You Take Daily**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Medical History: Please mark all that apply.

Acid Reflux/Heart Burn		Arthritis	
Anemia		Asthma	
Anxiety		Bipolar Disorder	
Blood Clots		Heart Arrhythmias (Atrial fibrillation)	
Cancer		Heart Disease (Heart attack)	
Congestive heart failure		Hepatitis (Liver infection)	
Chronic Constipation		High Cholesterol	
Chronic Diarrhea		HIV/AIDS	
Cirrhosis/Liver disease		Hypertension	
COPD/Lung fibrosis		Hypothyroidism or Hyperthyroid	
Depression		Kidney Disease	
Diabetes Mellitus Type 1 or 2		Lung Disease	
Diverticulitis		Pancreatitis	
Epilepsy		Pseudotumor Cerebri	
Fibromyalgia		Sleep Apnea	
Gallbladder disease		Stroke	
Gastric Ulcers		Other:	
Gout		Other:	

Surgical History: Please mark all that apply.

Appendectomy		Hysterectomy	
Back/Spine Surgery		Joint Replacement	
Brain Surgery		Open Heart Surgery	
Breast Surgery		Pacemaker	
Colon or Rectal Surgery		Plastics Surgery	
C-section		Prostate surgery	
Cosmetic Surgery		Small Intestine Surgery	
Defibrillator		Stent Placement	
Eye Surgery		Valve Replacement	
Fracture Repair		Vasectomy	
Gallbladder Surgery		Other:	
Hernia Surgery		Other:	

Prior Bariatric Surgery	Type:	
Results	Pre-op weight	Maximum weight loss
When/Where/Surgeon Name?		

Family History:

Relationship	Living/Deceased	Heart Disease	Cancer	Clotting Disorder	Diabetes	Hypertension	Kidney Disease	Lung Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

Social History: Please mark all that apply.

Current tobacco/nicotine use (also Vaping/Dipping)		Type?	How much per day?
Prior tobacco history		Type?	Quit Date?
Current alcohol use		How Often?	How Much?
Current drug use (also CBD/ marijuana)		Type of Drug?	How Often?

Domestic Abuse History:

Is abuse, violence, or sexual assault a problem for you in any way? ☐ Yes ☐ No

Does your partner/caregiver threaten you in any way? ☐ Yes ☐ No

System Review: Please list any active problems?

Constitutional		Visual disturbance		**Gastrointestinal**		**Blood**	
Appetite change		Hearing loss		Abdominal distention		Easy bleeding/bruising	
Chills		Tinnitus (ringing)		Abdominal pain		Blood clots	
Sweating		Hoarseness		Rectal bleeding		**Skin**	
Fatigue		Nose bleeds		Blood in stool		Pallor	
Fever		Voice change		Constipation		Rash	
Weight change		Dental problems		Diarrhea		Swelling	
Nervous System		**Heart and Lungs**		Nausea		**Psychiatric**	
Headaches		Chest pain		Vomiting		Nervous/anxious	
Dizziness		Leg swelling		**Muscle/Joints/Bones**		Self-injury	
Fainting		Palpitations		Arthralgia (joint pain)		**Other**	
Memory loss		Apnea		Back pain		**Urinary System**	
Eyes/Ears/Throat		Chest tightness		Gait problem		Frequent urination	
Redness		Wheezing/Stridor		Myalgia (muscle pain)		Blood in urine	

Obstructive Sleep Apnea Evaluation

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Score
1. Sitting and Reading	
2. Watching TV	
3. Sitting inactive in a public place (e.g. a theater or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch with alcohol	
8. In a car, while stopped for a few minutes in traffic	
Total Score:	

Sleep Apnea Treatment:

Question	
1. Are you currently using a dental device for snoring or sleep apnea?	Type of device
2. Have you ever worn a dental device or snoring or sleep apnea?	Type of device
3. Are you currently using CPAP/bi-level therapy? ☐ Yes ☐ No	
4. Have you ever been placed on CPAP/Bi-level therapy? ☐ Yes ☐ No	When did you start therapy?
5. Have you ever had surgery for snorting or sleep apnea? ☐ Yes ☐ No	

Sleep Behaviors: Please mark all that apply.

Behavior	
I have sometimes fallen asleep at inappropriate times such as driving, eating, or during a conversation.	
I have been told that I snore loudly.	
I sometimes wake up with a headache.	
I have been told that I stop breathing when I sleep.	

Mental Health History: Please mark all that apply.

Have you ever been diagnosed with any of the following:

Alcoholism	
Anxiety	
Bipolar Disorder	
Depression	
Obsessive Compulsive Disorder	
PTSD	
Schizophrenia	
Other:	

1. Have you ever been hospitalized for a psychiatric condition?
   a. If so when? ______
   b. Reason? ______
   c. Where? ______
2. Are you currently receiving treatment by a psychiatrist for medication management?
   a. Name of Psychiatrist ______
3. Are you currently receiving counseling from a psychologist?
   a. Name of Psychologist? ______
4. Over the last 2 weeks, how often have you been bothered by the following problems (score in the box below)?

0 = not at all
1= Several days
2= More than half the days
3= Nearly every day

a) Little interest of pleasure in doing things	
b) Feeling down, depressed, or hopeless	
c) Trouble falling or staying asleep or sleeping too much	
d) Feeling tired or having little energy	
e) Poor appetite or overeating	
f) Feeling bad about yourself, or that you are a failure, or have let yourself or family down	
g) Moving or speaking slowly where other people have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	
Total Score:	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult

Rex Bariatric Specialists

Name:
DOB:

NUTRITIONAL AND DIET QUESTIONNAIRE

A. Weight/Dieting History:

1. When did you begin to struggle with weight gain?
   a. Life-long struggle since childhood
   b. At age ________
2. Please list your heaviest adult weight (exclude pregnancies): __________ lbs __________ age.
3. Please list your lowest adult weight: __________ lbs __________ age.
4. Have you tried weight loss through structured dieting or other treatment? ☐ Yes ☐ No
5. If yes, list all food/ liquid diets or treatments attempted. Many insurance carriers require this information; therefore, please provide an accurate and complete listing.

Common Diets/Programs:
21 Day Diet
Atkins/Low Carb
Grapefruit
Jenny Craig
Liquid Protein
Metabolife
Nutri-System
Optifast/Medifast
Paleo
Physicians Weight Loss Center
Slim Fast
South Beach Diet
TOPS
Weight Watchers
Volumetrics
Zone Diet

Behavioral Treatments:
Diet Counseling/Worked with Dietitian
Exercise Trainer
Hypnosis
Personal Physician
Residential Diet Center

Name of Diet/Treatment	Lbs. Lost	Physician directed?

6. List all medications used by you for weight loss. Listed below are the most common medications. Please provide an accurate and complete list of any medications used in the past: Acutrim, Alli, Bontril, Didrex, Phentermine, Xenical, Dexatrim, Fen/Phen, Meridia, Redux.
7.

Medication & Dose	Start year	Length (Mos.)	Lbs. Lost	Physician directed

NUTRITIONAL PRE-SCREENING ASSESSMENT

8. What is motivating you to have weight loss surgery? Please list 3 reasons that will help motivate you to meet your goals.
   a.____
   b.____
   c.____

9. Have you had weight loss surgery in the past?
   a. Physician:________________________
   b. Date:________________________
   c. Type of Surgery: ________________________
   d. Weight When You Began Program:____________
   e. Total Pounds Lost:________________________

10. Have you ever been diagnosed and/ or have been treated for an eating disorder in the past?
    a. *Explain*______________________________

11. Do you have diabetes?
    a. No
    b. Yes
       i. Type 1 Diabetes
       ii. Type 2 Diabetes (known as adult onset)

    Are you testing daily blood sugars daily? __________
    If yes, what is your recent blood sugar range? __________
    Do you use insulin? ________
    Type________ Units________
    Type________ Units________

12. Are you on dialysis? ______________________________
    *Renal dietitian contact info:*________________________

13. Current use of nicotine?
    (ie. Cigarettes/e-cigarettes/cigars/pipes/chewing tobacco/nicotine gums or patches)
    a. Type? ______________________________
    b. Frequency/Amount ________________________

NUTRITIONAL PRE-SCREENING ASSESSMENT

Diet Behaviors (circle all that apply)

1. Current challenges to improving my health include:
   a. Lack of time
   b. Lack of motivation
   c. Work Schedule
   d. Too expensive
   e. Social Calendar
   f. Family responsibility
   g. Illness or physical limitation
   h. Traveling for work, etc
   i. Other__________________

2. My hidden sources of extra calories most likely come from:
   a. Large portions
   b. Soda/other beverages
   c. Sweets
   d. Chips
   e. Fried foods
   f. Eating while cooking
   g. Going out to eat
   h. Eating with distractions (TV/driving/etc)
   i. Eating when upset/stressed
   j. Eating when bored
   k. Other: _________________

3. How do you feel about making behavioral changes?
   a. Ready to start making changes now
   b. Ready to think about making changes
   c. Not ready to make any changes to my current lifestyle

4. How many meals do you eat out per week?

a.	Breakfast: ______	Fast food	Café	Cafeteria	Restaurant
b.	Lunch: _________	Fast food	Café	Cafeteria	Restaurant
c.	Dinner: _________	Fast food	Café	Cafeteria	Restaurant

5. Do you skip any meals?
   a. Breakfast — How many days per week?______
   b. Lunch — How many days per week?______
   c. Dinner — How many days per week?______

6. How often do you eat between meals?
   a. Seldom
   b. 1 time per day
   c. 2 time per day
   d. Graze throughout the day

7. What best describes your evening meal?
   a. Seldom eat dinner
   b. Lightest meal of the day
   c. Moderate size meal
   d. Largest meal of the day

8. Which sources of protein do you eat most often?
   a. Red meat (beef and pork)
   b. Fish and Chicken
   c. Eggs and Dairy
   d. Tofu, beans, and lentils

9. How your proteins are normally prepared? (choose all that apply)
   a. Grilled
   b. Sautéed with butter/ oils
   c. Baked/ Roasted
   d. Fried

NUTRITIONAL PRE-SCREENING ASSESSMENT

10. How many servings of fruit do you consume each day: ____________________

11. How many servings of vegetables do you consume each day: ______________
    a. Prepared with cheese, butter, or dressing
    b. Canned
    c. Fresh
    d. Frozen

12. Which types of carbohydrates do you choose most often:
    a. I avoid carbs
    b. Whole grains (brown rice/bulgar/barley/quinoa/ whole grain breads)
    c. Starchy vegetables (potatoes/peas/corn/beans)
    d. White/refined carbs (white rice/white pasta/white bread)
    e. Sweets (candies/cakes/muffins/etc)

13. How often do you eat low-fat dairy products?
    a. Seldom
    b. 1-2 times per week
    c. 1 time per day
    d. 2 times per day

14. Which types of drinks do you choose most often?
    a. Water
    b. Flavored water
    c. Fruit juice
    d. Coffee
    e. Sweet Tea
    f. Unsweet Tea
    g. Regular Soda
    h. Diet Soda/ seltzer waters

15. How many ounces of water do you drink on average each day? _________ ounces

16. How much alcohol do you consume?
    a. Less than 1 beverage per month
    b. 2-4 beverages per month
    c. 1-2 beverages per week
    d. 1-2 beverage per day
    e. 2-3 beverages per day
    f. Specify other: ______________________

17. How often do you exercise for 20 minutes or more each week?
    a. Seldom
    b. 1-2 times per week
    c. >3 times per week

    Please specify current exercise type/ duration___________________________
    Do you have any limitations/current barriers to increasing exercise?___________________
    What exercise has your physician asked you to do? ______________________________

18. How many hours of sleep do you typically get a night?
    a. 1-2 hours
    b. 3-4 hours
    c. 5-6 hours
    d. 7 or more hours.

19. What changes have you made since starting the bariatric program?
    a. Reduced refined carbohydrates ("white foods")
    b. Increased physical activity
    c. Increased water consumption
    d. _________________________