ST. LOUIS BARIATRICS, LLC
1400 U.S. Highway 61, Suite G50
Festus, MO 63028
314.366.4874 TEL 314.366.4875 FAX

NEW PATIENT INFORMATION FORM

Please complete all sections. Completed form can be saved and sent as an email attachment to **info@stlouisbariatrics.com** or can be printed out then faxed or mailed to the address above.

DEMOGRAPHICS

Last Name	First	Middle	Preferred Name

Date of Birth	Sex	SSN	Height	Weight	BMI

Ethnicity:	African American	Asian	Caucasian	Hispanic	Native American	Other

CONTACT INFORMATION

Mailing Address	City	State	Zip

Primary Phone Number	Alternate Phone Number	Fax Number (if applicable)

E-mail Address	Would you like a reminder email for future clinic appointments? YES NO

What is your preferred metho0d of contact with our office?	Email	Cell	Work

EMPLOYER INFORMATION

Employer	Occupation	Is it OK to contact you during work hours? YES NO

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Emergency Contact Number	Relationship

REFERRAL SOURCE

How did you hear about St. Louis Bariatrics?

Friend	Relative	Physician Referral	Internet	Social Media	Other (please specify):

Please list the person we should credit for referring you to our office for our Referral Program:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I substantiate that the above rendered information is true and complete to the best of my knowledge and ability.

Patient Signature Date

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name			
Primary Insured Last Name	Primary Insured First Name	Primary Insured Date of Birth	Patient Relationship to Primary Insured
Subscriber ID Number	Group Number	Are you aware of the need for a referral for your insurance company for our services? YES NO	

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name		
Secondary Insured Last Name	Secondary Insured First Name	Secondary Insured Date of Birth
Subscriber ID Number	Group Number	Patient Relationship to Secondary Insured

PRIMARY CARE PROVIDER INFORMATION

Name of Primary Care Clinic			
Primary Care Last Name	Primary Care First Name	Credentials (MD, DO, FNP)	
Primary Care Address	Primary Care City	Primary Care State	Primary Care Zip

OTHER MEDICAL SPECIALISTS WHO CURRENTLY TREAT YOU

Specialist Name	Specialty	Contact Information
Specialist Name	Specialty	Contact Information

WEIGHT HISTORY

2011	2012	2013	2014	2015
lbs.	lbs.	lbs.	lbs.	lbs.

Highest Weight Since Age 18	Lowest Weight Since Age 18	Age at lowest weight achieved

For how long have you tried to lose weight?	For how long have you been researching weight loss procedures?

HEALTH HISTORY			
Have you *ever* been diagnosed with any of these medical problems? If yes please add detail in the space provided.			
			Details:
High Blood Pressure	NO	YES	
Congestive Heart Failure	NO	YES	
Heart Attack	NO	YES	
Chest Pain related to your heart	NO	YES	
Heart Catheterization	NO	YES	
Stroke	NO	YES	
Blood clots in your legs or lungs	NO	YES	
Gout	NO	YES	
Lower Extremity Swelling	NO	YES	
Diabetes or High Blood Sugars	NO	YES	
High Cholesterol	NO	YES	
Hyperthyroidism/hypohyroidism	NO	YES	
Snoring	NO	YES	
Sleep Apnea	NO	YES	
Pulmonary Hypertension	NO	YES	
Asthma	NO	YES	
Back or Leg Pain requiring treatment	NO	YES	
Disorder similar to Lupus or Rheumatoid Arthritis	NO	YES	
Barrett's Esophagus	NO	YES	
Crohn's Disease or Ulcerative Colitis	NO	YES	
Heartburn, Reflux, GERD	NO	YES	
Gastroparesis	NO	YES	
Liver disease or Abnormal Liver Tests	NO	YES	
Hepatitis B or Hepatitis C	NO	YES	
Gallbladder Problems	NO	YES	
Polycystic Ovary Syndrome (PCOS)	NO	YES	
Urinary Stress Incontinence	NO	YES	
Depression, Bipolar, Anxiety Disorder	NO	YES	
Can you walk more than 200 ft without assistance?	NO	YES	
Are you on chronic Steroids (ie prednisone)?	NO	YES	
Do you know of any problems with your kidneys?	NO	YES	
Are you currently prescribed blood thinners?	NO	YES	
Do you have HIV/AIDS	NO	YES	
Previous Weight Loss Procedure	NO	YES	
Previous surgery on your stomach or esophagus	NO	YES	
Are you on disability	NO	YES	
Other medical problems not listed:			

MEDICAL HISTORY

List Below any other medical problems not previously discussed:

SURGICAL HISTORY

List below any prior surgeries you have undergone:

FAMILY HISTORY

Which illnesses run in you family:

High Blood Pressure	Diabetes	High Cholesterol	Stroke	Obesity	Bleeding or Clotting Disorders
Colon or Rectal Cancer		Stomach or Esophgeal Cancer		Heart Disease or Heart Attack	

SOCIAL HISTORY

Do you use any nicotine products?

NO	YES	Quantity:	Date Quit:

Do you consume alcohol?

NO	YES	Quantity:

Do you have history of prescription or non-prescription substance abuse?

NO	YES

MEDICATIONS

List below all current medications

MEDICATION ALLERGIES

List below *medication* allergies and reaction experienced (rash, throat swelling etc):

Created1/4/2016