BSC DALLAS
BARIATRIC SURGERY CENTER OF DALLAS

James A. Davidson, MD, FACS, FASMBS

PATIENT REGISTRATION FORM

(Please Print)

Name: ____________________
LAST FIRST MI

Street Address: ____________________
STREET APT CITY STATE ZIP

Home Phone #: ( ) ________ Cell Phone #: ( ) ________

Social Security #: ________ Birth date: ________ Age: ____ Sex: M ____ ; F ____

Marital Status: S M W D Ethnicity: ________ E-Mail address: ________

How Did You Hear About BSC Dallas? ________

Employment Status: ☐ Full Time; ☐ Part Time; ☐ Self Employed; ☐ Homemaker; ☐ Student;
☐ Retired; ☐ Disabled; ☐ Unemployed

Employer: ________ Occupation: ________

Employer Address: ________ Business Phone #: ( ) ________

Spouse Name: ________ Birth date: ________

Employer: ________ Business Phone #: ( ) ________

Emergency Contact information:

Name: ________ Home Phone #: ( ) ________

Address: ________ Other Phone #: ( ) ________

Relationship: ☐ Spouse; ☐ Partner; ☐ Friend; ☐ Parent; ☐ Other ________

Referring Physician:

Name: ________ Specialty: ________ Phone #: ________

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WEIGHT LOSS HISTORY

Patient Name: ______ Date of Birth: ______ Age: ______

How many years have you been overweight? ______ Have you had previous weight loss surgery? ______ No; ______ Yes

Procedure: ______ Date: ______

Diet Programs Previously Attempted

Program	Number of times attempted	Date of most recent attempt	Medically supervised	Amount of weight loss
Calorie/Carb counting				
Weight Watchers				
Richard Simmons				
Jenny Craig				
Nutri-System				
South Beach				
Slim Fast				
Atkins				
Optifast				
Medifast				
Herbalife				
Metabolife				
Other:				

Weight Loss Medication History

Medication	Number of times attempted	Date of most recent attempt	Medically supervised	Amount of weight loss
Amphetamines				
Phentermine				
Phen-Fen				
Redux				
Xenical				
Meridia				
Alli				
Other:				

Non Dietary or Medication Weight Loss Therapies

Therapy	Number of times attempted	Date of most recent attempt	Medically supervised	Amount of weight loss
Regular exercise				
Hypnosis				
Behavior modification				
Acupuncture				
Other:				

Patient Name: ☐ Date of Birth: ☐ Age: ☐

Social History:

Do you use tobacco: ☐ yes ☐ no. Packs per day: ☐ Age started: ☐ Age quit: ☐

Do you drink caffeine: ☐ yes ☐ no. Type: ☐ Amount per day: ☐

Do you drink alcohol: ☐ yes ☐ no. Amount: ☐ Frequency: ☐

Eating style (mark all that apply): ☐ Big eater ☐ Sweets ☐ Snacker ☐ Grazer

Have you ever been treated for depression/anxiety: ☐ yes ☐ no. Are you currently in treatment: ☐ yes ☐ no

Medical/System Review (please check all that apply)

General

- ☐ Fatigue
- ☐ Tiredness
- ☐ Unintentional Weight Loss
- ☐ Recent fever
- ☐ Night Sweats

Head and Neck

- ☐ Blurred/double vision
- ☐ Loss of vision
- ☐ Sinus/allergy problems
- ☐ Runny nose
- ☐ Sneezing
- ☐ LOSS of Smell
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hoarseness

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Cardiovascular

- [ ] Chest pains
- [ ] Previous heart attack
- [ ] Heart pounding/lpalpitations
- [ ] Heart murmur
- [ ] Pain in legs
- [ ] Cold feet
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Abnormal heartbeat
- [ ] Elevated cholesterol
- [ ] Elevated triglycerides
- [ ] Previous Blood Transfusions

Respiratory

- [ ] Shortness of Breath
- [ ] Asthma
- [ ] Wheezing
- [ ] Coughing
- [ ] Bloody sputum
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Bronchitis
- [ ] Problems laying flat
- [ ] Waking at night
- [ ] CPAP/BIPAP

Gastrointestinal

- [ ] Jaundice
- [ ] Hepatitis
- [ ] Cirrhosis
- [ ] Fatty liver
- [ ] Nausea (persistent)
- [ ] Vomiting (persistent)
- [ ] Stomach pain
- [ ] Diarrhea
- [ ] Constipation
- [ ] Blood in stools
- [ ] Irritable Bowel
- [ ] Colitis

Genitourinary

- [ ] Blood In urine
- [ ] Frequent urination
- [ ] Leakage of urine
- [ ] Trouble starting urine

Endocrine

- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Goiter
- [ ] Any radiation
- [ ] Diabetes, Type: [ ]
- [ ] Adrenal tumors
- [ ] Steroid use

Musculoskeletal

- [ ] Painfull/swollen joints
- [ ] Gout
- [ ] Muscle aches
- [ ] Arthritis
- [ ] Pain in knees
- [ ] Pain in hips
- [ ] Pain in ankles
- [ ] Pain in feet
- [ ] Low back pain
- [ ] Herniated disk
- [ ] Sciatica
- [ ] Weakness

Neurological

- [ ] Seizures
- [ ] Fainting
- [ ] Dizziness
- [ ] Vertigo
- [ ] Failing
- [ ] Numbness
- [ ] Tingling
- [ ] Tremors
- [ ] Headaches
- [ ] Migraines

Bariatric Surgery Center of Dallas
8210 Walnut Hill Lane Dallas, Tx 75231
Office: 469-330-6781
Fax: 469-624-1105
Web: http://www.bscdallas.com
Email: bscdallas@bscdallas.com
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Skin

- [ ] Skin cancer
- [ ] Rash
- [ ] Eczema
- [ ] Psoriasis
- [ ] Burn scars
- [ ] Other

Women

- [ ] Menses regular
- [ ] Menses irregular
- [ ] Post menopausal
- [ ] # of pregnancies
- [ ] # of children

Psychological

- [ ] Depression
- [ ] Anxiety
- [ ] Nervousness
- [ ] Suicide thoughts
- [ ] Suicide attempts
- [ ] Schizophrenia
- [ ] Bipolar
- [ ] Anorexia
- [ ] Bulimia
- [ ] Binge eating

Reviewed by: ______________________ Date: __________

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PATIENT HISTORY/REVIEW OF SYSTEMS

Patient Name: | Date of Birth: | Age:

Current Medications

Medication	Dosage	Frequency	Reason

Drug allergies/reaction:

Previous Surgeries

(Please list all operations and surgical procedures)

Procedure	Dosage	Location	Reason

Family History

(Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Stroke								
Early Death								

Health Insurance Information:

Primary Insurance Co: ____ Phone #: ____

ID#: ____ Policy #: ____ Group #: ____

Policy Holder Name: ____ Relation to Patient: ____

Policy Holder SS#: ____ Birth date: ____

Secondary Insurance Co: ____ Phone #: ____

ID#: ____ Policy #: ____ Group #: ____

Policy Holder Name: ____ Relation to Patient: ____

Policy Holder SS#: ____ Birth date: ____

ASSIGNMENT OF BENEFITS & SIGNATURE ON FILE

I authorize direct payment to Dr. James Davidson. I authorize the use of this form for all insurance submissions, and permit a copy of this to be used in place of the original. I authorize this provider to act as my agent in helping me obtain payment from my Insurance company. I expressly revoke all prior revocations of any assignment of benefits. In the event that my current policy prohibits direct payment to the provider, then I hereby instructs and direct you to make out the check to me and mail in care of the Named provider. I certify that all the information is true and correct to the best of my knowledge. I will notify you of any changes in my health, the above information, or any other information. I understand that I am responsible for fees of any services rendered to me, regardless of any insurance or financial class. I understand that Dr Davidson's office uses a service to check benefits, predetermination, pre-certification, and file insurance claims.

Signature: ____ Date: ____