



MedStar Franklin Square  
Medical Center

**Patient Registration**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Emergency Contact** Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_

**Preferred methods of communication:** Which phone number(s) do you prefer us to call?

Home phone # \_\_\_\_\_ Ok to leave voicemail  YES  NO

Work phone # \_\_\_\_\_ Ok to leave voicemail  YES  NO

Cell phone # \_\_\_\_\_ Ok to leave voicemail  YES  NO

When we mail information, may we use:

Envelope with office return address  Plain envelope  DO NOT MAIL

Mailing address: (if different from above)

Street Address \_\_\_\_\_

City, State Zip code \_\_\_\_\_

Do you have trouble hearing or understanding information over the phone?  Yes  No

Would you like us to discuss your healthcare needs with a caregiver, family member, or significant other?

Yes  No

If yes: Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

May we discuss the following (check ALL items that apply)

Appointments  Billing Issues  Medications  All healthcare information

Who would you prefer us to leave a message with?  DO NOT LEAVE A MESSAGE WITH ANYONE

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone \_\_\_\_\_



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Insurance Coverage

Primary Insurance

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders Date of birth: \_\_\_\_\_

Secondary Insurance

Insurance Company: \_\_\_\_\_ Member ID: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders Date of birth: \_\_\_\_\_

**Patient's Authorization**

I hereby authorize my insurance benefits to be paid to my physician. I certify the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.

This office will prepare insurance forms for covered services to assist in making collections from the insurance company. In an effort to keep our fees as low as possible, we find it necessary to expect our patients to pay for non-covered services they receive at the time of service.

This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility to pay medical services provided, when a statement is rendered.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

## Financial Policy

The following is a statement of our Financial Policy in which we ask that you read and sign prior to any treatment. You will also be given a copy of the signed paper for you to refer to.

### **Patient Responsibilities:**

Your insurance is a contract between you and your insurance company. You are responsible for ALL deductibles, co-pays, and coinsurance. We cannot “write off” any amount that is your responsibility. Please be aware that some and perhaps all of the services provided may be a non-covered service (or not considered “medically necessary”) and are therefore your responsibility.

### **Co-pays and Balances:**

Your co-pay is expected at the time of service. If you do not have your co-pay with you, we reserve the right to reschedule your appointment. You are responsible for any amount not covered by your insurance at the time or service, including office visit co-pays. If your insurance company has not paid your bill within 45 days, the balance will be billed to you. Balances will need to be paid in full prior to scheduling any followUp appointments or procedures. You will be held responsible for collection and legal costs should it be necessary for this account to be turned over to a collection agency.

### **Referrals:**

You are responsible for obtaining referrals from your primary care provider if required by your insurance company. You are also responsible for keeping track of the number of approved visits and the duration for which the referral remains valid. Our office staff is not required to call your doctor’s office for you regarding your referral. If you come to the office without a referral, or with an expired referral, or with a referral with no more authorized visits on it, we have the right to reschedule your appointment.

### **Fees:**

Form Fees: There will be a \$15.00 fee per form that needs to be filled out by the doctor. You must allow at least five to seven business days for the completion of any form(s).

“No Show” Fees: We require 24 hours notice to cancel your appointment. You may be charged a \$30 fee for not cancelling your appointment within 24 hours. Any patient missing three appointments within a 6 month period may result in dismissal of care. Consideration will be given to those with TRUE medical emergencies, illness, or death in the family.

I have read, understand, and agree to this financial policy.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

### Patient Safety Screen

WE CARE ABOUT YOUR SAFETY!

Please help us by providing information about any safety issues you may have while under our care. For each section below, **check ALL items that apply** to you. You may provide an additional explanation in the line below each section.

**INTAKE INFORMATION:**

**Preferred Language:** English Spanish Other \_\_\_\_\_

**Communication Needs:** NONE Interpreting Needed TTY ASL

**Education Level:** High School College Other \_\_\_\_\_

**Learning Preference:** No preference Verbal Visual Written Lip reading

**Barriers to learning:** None Difficulty Vision Impairment Hearing Impairment Learning disorder

**Religious Preference:** None Catholic Christianity Judaism Islam Buddhism Hinduism  
Jehovah's Witness

**Advance Directives:** Written information provided Written information declined On file

**Caregiver at home:** NO YES

**Name of Caregiver:** \_\_\_\_\_

### Provider Names

In order to ensure appropriate coordination of care, please provide the names and phone numbers of any doctors you are currently seeing or have seen in the immediate past.

Primary Care Physician: Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Referring Physician: Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Any Other Physicians Currently Being Seen:

Physician Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Specialty: \_\_\_\_\_



Patient Name: \_\_\_\_\_

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**Pharmacy :** Name: \_\_\_\_\_

Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Allergies:**  Check if no allergies

Allergy	Type of reaction

**Current medication (prescription and non-prescription):**  Check if no medications

Medication	Dosage	Times per Day	Purpose



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Medical History (**

**Check if no medical history**

<b>Cardiovascular Disease</b>	<b>Musculoskeletal</b>
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Deep venous thrombosis (clot in the leg)	<input type="checkbox"/> Musculoskeletal disease
<input type="checkbox"/> Pulmonary embolism (clot to the lung)	<b>Psychiatric</b>
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Lower leg swelling	<input type="checkbox"/> Anxiety/Panic disorder
<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Personality disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Psychosis
<b>Gastrointestinal</b>	<input type="checkbox"/> Depression
<input type="checkbox"/> Gallstones with symptoms	<b>Pulmonary</b>
<input type="checkbox"/> Reflux	<input type="checkbox"/> Asthma
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sleep apnea
<b>General</b>	<input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Abdominal hernia	<b>Reproductive</b>
<input type="checkbox"/> Abdominal skin/pannus	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Pseudotumor cerebri	<input type="checkbox"/> Menstrual Irregularities
<input type="checkbox"/> Stress urinary incontinence	<b>Other</b>
<b>Metabolic</b>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/>
<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol	<input type="checkbox"/>



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Surgical History (check all that apply):  Check if no surgical history**

Surgery	Date	Comment
<input type="checkbox"/> Previous bariatric surgery		Type: Initial weight:                      Lowest weight achieved:
<input type="checkbox"/> Anti-reflux procedure		
<input type="checkbox"/> Appendectomy		
<input type="checkbox"/> Bowel resection		
<input type="checkbox"/> Breast cancer, biopsy		
<input type="checkbox"/> Breast cancer, mastectomy		
<input type="checkbox"/> Breast cancer, radiation		
<input type="checkbox"/> CABG		
<input type="checkbox"/> Cesarean section		Number:
<input type="checkbox"/> Gallbladder		Open / Laparoscopic
<input type="checkbox"/> Discectomy		
<input type="checkbox"/> Hip Replacement		
<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Knee replacement		
<input type="checkbox"/> Laminectomy		
<input type="checkbox"/> Nissen fundoplication		
<input type="checkbox"/> Peripheral vascular procedure		
<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> Vagotomy		
<input type="checkbox"/> Vasectomy		
<input type="checkbox"/> Hernia		Type:
<input type="checkbox"/> Other: (list surgeries and year)		



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Family History:**

Relationship	Alive	Age	Health Problems	
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____
Maternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____
Maternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____
Paternal Grandmother	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____
Paternal Grandfather	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other:	<input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer: _____





Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Social History**

<p>Education:</p> <p><input type="checkbox"/> 9 to 11 years</p> <p><input type="checkbox"/> High School Graduate</p> <p><input type="checkbox"/> Vocational/ Technical</p> <p><input type="checkbox"/> Attended College</p> <p><input type="checkbox"/> College Graduate</p> <p><input type="checkbox"/> Post Graduate</p>	<p>Do you use nicotine? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what kind: If yes, how much:</p> <p><input type="checkbox"/> Cigarettes</p> <p><input type="checkbox"/> Cigars</p> <p><input type="checkbox"/> Chewing tobacco</p> <p><input type="checkbox"/> Vapor</p> <p>Former user: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date last used:</p>
<p>Number of Children:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>	<p>Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>History of alcohol abuse:</p> <p>If yes, how much: If yes, how often:</p> <p><input type="checkbox"/> Less than 2 per day <input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Between 2 – 5 per day <input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Between 6 – 10 per day <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> More than 11 per day <input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/></p>
<p>Religion:</p> <p><input type="checkbox"/> Atheist</p> <p><input type="checkbox"/> Christian</p> <p><input type="checkbox"/> Catholic</p> <p><input type="checkbox"/> Jewish</p> <p><input type="checkbox"/> Jehovah's Witness</p> <p><input type="checkbox"/> Muslim</p> <p><input type="checkbox"/> Other:</p>	<p>Do you use illegal drugs? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>History of drug abuse:</p> <p>If yes, what kind: If yes, how often:</p> <p><input type="checkbox"/> Marijuana <input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Cocaine <input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Heroin <input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Amphetamine <input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/> Other: <input type="checkbox"/></p>



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Review of Systems (check all that apply)**

GENERAL	NOSE	LUNGS	GENITOURINARY
<input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Swelling of lymph nodes	<input type="checkbox"/> Nosebleed <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nasal discharge or post-nasal drip	<input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Chest pain with deep breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Blood in sputum <input type="checkbox"/> Stopping of breathing during sleep	<input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Blood in urine <input type="checkbox"/> Foamy urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Unusually dark urine <input type="checkbox"/> Flank or side pain <input type="checkbox"/> h/o kidney stones <input type="checkbox"/> Decreased sexual drive <input type="checkbox"/> Impotence
	MOUTH	GASTROINTESTINAL	SKIN
	<input type="checkbox"/> Cavities - untreated <input type="checkbox"/> Dentures <input type="checkbox"/> Sores/ulcers <input type="checkbox"/> Change in voice	<input type="checkbox"/> Nausea and/or Vomiting <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Jaundice (yellow skin discoloration) <input type="checkbox"/> Vomiting of blood <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Change in nails <input type="checkbox"/> Hair growth or loss
HEAD	HEART	MUSCULOSKELETAL	NEUROLOGIC
<input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo <input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Fainting <input type="checkbox"/> Shortness of breath with exertion <input type="checkbox"/> Difficulty breathing when lying flat <input type="checkbox"/> Waking up from sleep unable to breathe <input type="checkbox"/> Swelling in the lower legs <input type="checkbox"/> Blue/purple skin discoloration <input type="checkbox"/> Cramping of legs with walking	<input type="checkbox"/> Pain and swelling of the joints <input type="checkbox"/> Back pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Restless leg	<input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Memory loss <input type="checkbox"/> Lack of muscle coordination <input type="checkbox"/> Tremor
NECK	BREAST	GENITOURINARY	PSYCHIATRIC
<input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Masses	<input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness <input type="checkbox"/> Swelling	<input type="checkbox"/> Urgency or frequency of urination <input type="checkbox"/> Involuntary leakage of urine <input type="checkbox"/> Decreased urinary stream <input type="checkbox"/> Pain with urination	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations
EYES			
<input type="checkbox"/> Visual changes <input type="checkbox"/> Double vision <input type="checkbox"/> Blind spots <input type="checkbox"/> Redness <input type="checkbox"/> Pain <input type="checkbox"/> Eye irritation			
EARS			
<input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Earache			



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**MedStar Franklin Square Medical Center  
Bariatric Surgery Program**

**I am interested in the following procedure(s):**

Roux-en-Y Gastric Bypass	<input type="checkbox"/>
Sleeve Gastrectomy	<input type="checkbox"/>
Lap-Band	<input type="checkbox"/>
Conversion or Revision Surgery	<input type="checkbox"/>

**In your own words, please let us know why you are considering surgery:**


**Obstructive Sleep Apnea Screening Questionnaire:**

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often feel tired, fatigued, or sleepy during the daytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone observed you stop breathing during your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have or are you being treated for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Which of the following life events have been associated with significant weight change?**

<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Quitting smoking	<input type="checkbox"/> Medication use
<input type="checkbox"/> Death in the family	<input type="checkbox"/> Illness in the family	<input type="checkbox"/> New job	<input type="checkbox"/> Change in job
<input type="checkbox"/> Retirement	<input type="checkbox"/> Suffering from illness	<input type="checkbox"/> Pregnancy Year: _____	<input type="checkbox"/> Other: _____



Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Have you been diagnosed with an eating disorder?**

<input type="checkbox"/> Compulsive overeating	<input type="checkbox"/> Binge eating	<input type="checkbox"/> Anorexia nervosa
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Laxative abuse	<input type="checkbox"/> Other

If yes- current/past treatment: \_\_\_\_\_

**Eating patterns**

<input type="checkbox"/> I eat 3 meals per day	<input type="checkbox"/> I eat 1 or 2 meals per day	<input type="checkbox"/> I tend to skip meals
<input type="checkbox"/> I skip breakfast	<input type="checkbox"/> I eat just before bedtime	<input type="checkbox"/> I eat in the middle of the night
<input type="checkbox"/> I prepare my own meals	<input type="checkbox"/> I eat at my desk	<input type="checkbox"/> I eat at the dining table
<input type="checkbox"/> I eat in front of the TV	<input type="checkbox"/> I eat "on the run"	<input type="checkbox"/> I eat at a restaurant or cafeteria several times a week

**Drinking patterns**

Drink	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many cups per day?
Diet soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Regular soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coffee	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Water	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Eating behaviors**

Please check all situations that apply where you eat when NOT really hungry:		
<input type="checkbox"/> Bored	<input type="checkbox"/> Anxious	<input type="checkbox"/> Talking on the phone
<input type="checkbox"/> Emotional	<input type="checkbox"/> Stressed	<input type="checkbox"/> Watching TV
<input type="checkbox"/> Reading	<input type="checkbox"/> Tired	<input type="checkbox"/> Gathered with friends





Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

### Lifestyle Changes

Do you feel you are ready to commit to and follow a healthy meal plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel you are ready to commit to an exercise program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel you have the support (family/friends) you need to be successful?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel you will be able to perform the work to achieve your goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel you have the motivation and dedication to achieve your goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No

It is your responsibility to remain in contact with the program up to five years post-op. Please keep the office updated with contact changes to include contact numbers and current address along with insurance coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

