

# Carlos A. Ferrari, M.D.

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## NEW PATIENT REGISTRATION FORM

Female    Male

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

SSN \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information

Name of insured \_\_\_\_\_ SSN \_\_\_\_\_

Policy/Certificate number \_\_\_\_\_ Group number \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Name of second insurance \_\_\_\_\_

Name of insured \_\_\_\_\_

Policy/Certificate number \_\_\_\_\_ Group number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

\*\* Please have your insurance ID card on hand so that we may photocopy it. \*\*

### Emergency Information

Who may we contact in case of emergency?

Name \_\_\_\_\_ Relation to you \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Reason for your visit \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

**I hereby authorize Dr. Carlos Ferrari to give my insurance company any information it may require concerning my case. I thereby authorize payment of any medical benefits for services provided by Dr. Ferrari to be paid directly to Dr. Ferrari.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Allergies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to latex?    Yes    No

Medications

What medications are you CURRENTLY taking?

<u>Name</u>	<u>Reason</u>	<u>Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you holding prescriptions for any medications that you are not taking? If yes, please list.

\_\_\_\_\_  
\_\_\_\_\_

Surgery History

<u>Date</u>	<u>Surgery</u>	<u>Hospital/doctor</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nonsurgical Hospitalizations (deliveries, dehydrations, etc.)

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last menstrual period \_\_\_\_\_ Last gynecological exam \_\_\_\_\_

Name of doctor \_\_\_\_\_  
Result \_\_\_\_\_  
Pregnancies \_\_\_\_\_ Dates of deliveries \_\_\_\_\_  
Date of last mammogram \_\_\_\_\_ Result \_\_\_\_\_

Have you ever received a blood transfusion?    Yes    No  
If yes, please answer the following questions.  
Year \_\_\_\_\_  
Where \_\_\_\_\_  
Reason \_\_\_\_\_

### Health Habits

Please check the substances you use and indicate how much you use.

\_\_\_\_\_ Caffeine  
If yes, how many cups of caffeinated drinks per day? \_\_\_\_\_  
\_\_\_\_\_ Tobacco (including cigars, pipes, and chewing tobacco).  
If yes, how much per day? \_\_\_\_\_  
\_\_\_\_\_ Recreational drugs  
If yes, what kind and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Sweets- Are you a "sweet eater" / do you eat desserts?  
If yes, what kind and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_

### Obesity History

Please be accurate and detailed with your answers. This information will be requested by your insurance company to preauthorize your case. This information is also important because it will help Dr. Ferrari make the appropriate medical decision.

Have you seen a doctor in the last year for morbid obesity?    Yes    No  
If yes, when? \_\_\_\_\_  
Doctor's name \_\_\_\_\_

How long have you been obese? \_\_\_\_\_

At what age did you start your first diet? \_\_\_\_\_

Weight loss attempts

Year    Diet program/doctor    Start & end weight    How long    Medication

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If you have ever taken prescribed weight loss medication, please list them.

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If you are currently taking any weight loss medication, please list them.

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Have you ever tried any of the following weight loss methods:

Hypnosis

Tapes

Acupuncture

Injections

Amino acids

Liquid protein

Slimfast

Metabolife

Exercise

Other \_\_\_\_\_

Do your family members know that you are considering having surgery to lose and control your weight?    Yes    No

Do your family members support your decision to have this surgery?  
Yes    No

Family Medical History

Please check if a family member has suffered from any of the following medical conditions.

	<u>Obesity</u>	<u>Heart Disease</u>	<u>Hypertension</u>	<u>Diabetes</u>	<u>Other</u>
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sibling(s)	_____	_____	_____	_____	_____
Grandmother(s)	_____	_____	_____	_____	_____
Grandfather(s)	_____	_____	_____	_____	_____
Aunt(s)	_____	_____	_____	_____	_____
Uncle(s)	_____	_____	_____	_____	_____

If any of the following family members are deceased, please indicate cause of death.

Mother	_____
Father	_____
Sibling(s)	_____
Grandmother(s)	_____
Grandfather(s)	_____
Aunt(s)	_____
Uncle(s)	_____

How Does Being Overweight Affect You?

Please check if you suffer from any of the following problems.

- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ High blood pressure
- \_\_\_\_\_ Leak of urine
- \_\_\_\_\_ Joint pain \_\_\_\_\_
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Varicose veins
- \_\_\_\_\_ Heartburn/reflux
- \_\_\_\_\_ Infertility
- \_\_\_\_\_ Missing menstrual periods
- \_\_\_\_\_ Rashes between thighs
- \_\_\_\_\_ Rashes between folds
- \_\_\_\_\_ Other \_\_\_\_\_

List any social problems \_\_\_\_\_

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Do you have trouble fitting in chairs, sitting in planes, or finding clothes?

Yes    No

Please state your reason(s) for wanting bariatric surgery.

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How did you find out about Dr. Ferrari? \_\_\_\_\_

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Have you read any information or literature about bariatric surgery?

Yes    No

If yes, how did you obtain this information?

\_\_\_\_\_ Internet \_\_\_\_\_

\_\_\_\_\_ From another doctor \_\_\_\_\_

\_\_\_\_\_ Our web page \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_