Welcome to Synergy Bariatrics

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Synergy Bariatrics is an internationally recognized group of experts in obesity and bariatric surgery. We offer a variety of weight loss services and are pleased to welcome you to our practice.

- Complete entire registration packet. Please make sure ALL questions are answered to the best of your ability and that you have signed and dated where indicated
- Obtain copies of picture ID and ALL insurance cards. Please be sure to copy the front AND back.
- Obtain a list of meds from your primary care provider.

Once you have completed and gathered all of the above information, please mail or drop off to:

Synergy Bariatrics
30 North Union Rd. Suite 104
Williamsville NY 14221

Once your paperwork is received, Synergy Bariatrics will process the information and call you to schedule your consultation.

<u>If you are planning on attending our IN HOUSE SEMINAR, please complete the above steps and BRING ALL DOCUMENTATION WITH YOU to the seminar.</u>

IN-HOUSE SEMINAR DATE: _____

ARRIVAL TIME: _____

After the seminar, Synergy Bariatrics will process your paperwork and contact you to schedule your consultation.

Synergy Bariatrics Patient Registration

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Last Name:	First Name:	Middle Initial:
SSN#:	**Birth Date:**	Gender: F □ M □
Marital Status: Annulled □ Divorced □ Domestic Partner □ Legally Separated □ Married □ Never Married □ Widowed □		
Race: White/Caucasian □ Black/African American □ American Indian/Alaskan Native □ Asian □ Native Hawaiian □ Other □ No Response □		
Ethnicity: Hispanic/Latino: □ Not Hispanic/Latino □ No Response □		
Preferred Language: English □ Spanish □ Other □: _____		

Address:	City:	State:	Zip:
Apt/PB BOX:	County:	Email:	
Home Phone: ( )	This is the □ Best □ 2nd best number to reach me		
Work Phone: ( )	This is the □ Best □ 2nd best number to reach me		
Cell Phone: ( )	This is the □ Best □ 2nd best number to reach me		

Primary Physician:	
Phone: ( )	**Fax: ( )**

Are you employed?: **NO** □ **RETIRED** □ **YES – Full Time** □ **Part Time** □	Occupation:	
Employer:		Phone: ( )
Employer Address:		
City:	State:	Zip:

Primary Insurance Company Name:		Is this a PPO? Yes □ No □
Policy Number:	Group Number:	
If policy holder is other than self, please indicate name:		
Relationship to policy holder:		
Policy holder DOB:	Policy holder SSN#:	
Secondary Insurance Company Name:		Is this a PPO? Yes □ No □
Policy Number:	Group Number:	
If policy holder is other than self, please indicate name:		
Relationship to policy holder:		
Policy holder DOB:	Policy holder SSN#:	

Do you have prescription coverage from a company other than your insurance carrier?: **YES** □ **NO** □
IF YES, PHARMACY ISSUER:
PATIENT ID:
--- PLEASE INCLUDE A COPY OF YOUR PRESCRIPTION COVERAGE CARD IF YOU HAVE ONE ---

Synergy Bariatrics
30 North Union Rd ○ Suite 104 ○ Williamsville NY 14221
PH: 716-565-3990 ○ FAX: 716-565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Synergy Bariatrics Patient Privacy and Contact Information Form

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Emergency Contact:	
Relationship:	Home phone: Cell Phone:

I. Please list family members or others, if any, with whom we may discuss your general medical condition and your diagnosis, including emergent situations:

_____

_____

III. May we leave confidential messages on your answering machine, voicemail or with a family member?

_____ Yes ☐ No ☐

IV. May we call you at work?

_____ Yes ☐ No ☐

V. If necessary, may we fax your information to another doctor's office or insurance company?

_____ Yes ☐ No ☐

VI. Please list any other pertinent information you would like us to know to preserve your privacy:

_____

_____

_____

I am aware that a cell phone is not a secure line.

Print Name: _____

Signature: _____

Synergy Bariatrics
30 North Union Rd ○ Suite 104 ○ Williamsville NY 14221
PH: 716-565-3990 ○ FAX: 716-565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Medical History and Health Record

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Name: DOB: Age:

Please tell us why you have chosen Synergy Bariatrics.

Please check any medical condition with which you have been diagnosed:

High cholesterol	□	Depression	□	Coronary artery disease	□
Hypothyroidism	□	Sleep apnea	□	Anxiety	□
Hyperthyroidism	□	Gastroesophageal reflux	□	COPD	□
High blood pressure	□	Seizures	□	Peptic ulcer Disease	□
Type 1 Diabetes	□	Peripheral vascular disease	□	Barrett's esophagitis	□
Type 2 Diabetes	□	History of a heart attack	□	Cancer	□
Blood clots	□	History of a stroke	□	If so type:	
Fatty liver	□	Pulmonary Embolism	□	Migraines	□
Crohn's disease	□	Ulcerative colitis	□	Irritable bowel syndrome	□
Arthritis	□	Hepatitis	□	Asthma	□
Other:					

Have you ever had surgery before? (Check all that apply)

Hernia repair	□	Cholecystectomy	□	Appendectomy	□
Hysterectomy	□	Hip replacement	□	Knee replacement	□
Oophorectomy	□	Tubal ligation	□	Cesarean Section	□
Bowel resection	□	Coronary artery bypass graft	□	Coronary artery stenting	□
Other:					

Have you ever had weight loss surgery in the past?: **□ Yes** **□ No**
If yes, which procedure and when?

Do you use any assistive devices for walking: □ Yes □ No
Type: _____

Do any of your immediate family members from the following conditions?

Condition		**Family Member**
Diabetes	□	
Blood Clots	□	
Stroke	□	
Heart Disease	□	
Heart Attack	□	
Pulmonary Embolism	□	
Cancer, list type	□	

Synergy Bariatrics
30 North Union Rd ○ Suite 104 ○ Williamsville NY 14221
PH: 716-565-3990 ○ FAX: 716-565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Social history:
Who lives with you?
Smoking history: □ I never smoked. □ I am a former smoker having quit on _____ after _____ years of _____ packs/day. □ I am currently smoking _____ packs/day.
Do you currently or have you ever used illicit drugs? If so, describe: _____ _____ _____
Alcohol history: □ I never drank. □ I am a former drinker having quit on _____ after _____ years. □ I am currently drinking (beer, wine, liquor) seldom, occasionally, regularly.

Please check any symptoms which you experience regularly:					
Chest pain	□	Gallbladder problems	□	Skin rashes	□
Shortness of breath	□	Indigestion/heartburn	□	Skin breakdown	□
Leg edema	□	Nausea	□	Dizziness	□
Palpitations	□	Vomiting	□	Difficulty swallowing	□
Non-healing ulcers	□	Bloody stools	□	Headaches	□
Cough	□	Urinary incontinence	□	Numbness/tingling	□
Snoring	□	Blood in urine	□	Anxiety	□
Wheezing	□	Urinary tract infections	□	Depression	□
Recurrent pneumonia	□	Back pain	□	Cold intolerance	□
Abdominal pain	□	Joint pain	□	Heat intolerance	□
Constipation	□	Muscle Weakness	□	Excessive thirst	□
Diarrhea	□	Skin infections	□		
Easy bruising	□	Bleeding/clotting disorder	□		
Blood transfusions	□	Anemia	□		
Women only:		**Infertility**	□	**Heavy periods**	□
		Menopause	□	**Breast masses**	□
Men only:		**Erectile dysfunction**	□	**Prostate problems**	□

The above is true and correct to the best of my belief.

Signature: _____

Date: _____

Synergy Bariatrics
30 North Union Road ○ Suite 104 ○ Williamsville NY 14221
Phone: (716) 565-3990 ○ Fax: (716) 565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Current Prescription and Allergy Record

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Name:	Date of Birth:
Pharmacy Name:	Pharmacy Phone #: ( )
Pharmacy Address:	City/State:
Insurance Name for Prescription Coverage:	ID/Rx#:

Do you currently take any prescription medications, including birth control, hormone replacements, vitamins, supplements or over the counter medications? □ **NO** □ **YES**

Medication Name	Dosage (mg)	Frequency	Reason for taking

Do you have allergies? □ **YES** □ **NO**

Include foods, medications, latex, bees, etc.

Allergen Name	Type and severity (mild, moderate or severe) of Reaction

Synergy Bariatrics
30 North Union Road ○ Suite 104 ○ Williamsville NY 14221
Phone: (716) 565-3990 ○ Fax: (716) 565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Weight Loss/Diet History

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Name: _____ DOB: _____

DATE (YEAR)	DIET/PROGRAM/MEDICATION	START DATE	END DATE	LBS LOST	LBS REGAINED
2015					
2016					
2017					
2018					
2019 - Present					

* PLEASE INCLUDE **AT LEAST ONE** ENTRY FOR **EACH YEAR** LISTED.
* THIS PAGE MUST BE FILLED OUT BY YOU BEFORE WE CAN REQUEST SURGERY FROM YOUR INSURANCE COMPANY
* PLEASE INCLUDE ANY/ALL WEIGHT LOSS ATTEMPTS/PROGRAMS YOU HAVE TRIED WITHIN THIS TIME FRAME. (WEIGHT-WATCHERS, JENNY CRAIG, LOW-CALORIE, LOW-CARBOHYDRATE, CUTTING OUT SWEETS/SODA ETC.)
* INCLUDE EXERCISE

Stamp Physician Name and Address

Primary Care Physician Documentation for Bariatric Surgery Approval

BRING THIS TO YOUR PRIMARY CARE DOCTOR

Patient Name:		Date of Birth:	
I am referring this patient to you for consideration of weight loss surgery for severe obesity.			
The patient has been morbidly obese for at least five years:		**□ Yes**	**□ No**
I have followed the patients diet/exercise for at least 6 months		**□ Yes**	**□ No**
My patient's height is:	Inches		centimeters
My patient's last recorded weight is:	pounds		kilograms
My patient's BMI is:			

My patient has the following co-morbidities:

□ Diabetes	□ Sleep apnea	□ Asthma
□ Hypertension	□ Depression	□ Pulmonary Disease
□ Arthritis	□ Degenerative Arthritis	□ GERD
□ Backache	□ Coronary Disease	
□ Other (please list)		

□ There is no significant liver, kidney, or gastrointestinal disease present.
□ There is no treatable cause for obesity such as adrenal or thyroid disorder.
□ There are no cardiac or pulmonary contraindications to bariatric surgery.
□ There is no history of alcohol or substance abuse.

*** (PLEASE NOTE! IF ANY BOX REMAINS UNCHECKED, PLEASE ADDRESS WHY):___

_____

_____

Independent Health Patients: TSH Level (Within last 6 months) _____

*** PLEASE ATTACH A LIST OF THE PATIENT'S CURRENT MEDICATIONS

The remainder of the physical examination is:
□ Unremarkable
□ Positive for: (please list) _____

By signing this form, I believe the patient is a good candidate for surgery and would benefit from significant weight loss. I would be happy to see the patient again prior to surgery for medical clearance.

_____ _____
Print name of Physician Date

_____
Signature

Please fax completed form to (716) 565-3988

Synergy Bariatrics
30 North Union Road ○ Suite 104 ○ Williamsville NY 14221
Phone: (716) 565-3990 ○ Fax: (716) 565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm