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** □

Pharmacy Name:	Pharmacy Phone #: ( )
Pharmacy Address:	City/State:
Insurance Name for Prescription Coverage:	ID/Rx#:
Do you have a mail order pharmacy requirement? If yes, please complete	
Pharmacy Name:	Pharmacy Phone #: ( )
Pharmacy Address:	City/State:
Insurance Name for Prescription Coverage:	ID/Rx#:

--- PLEASE INCLUDE A COPY OF YOUR PRESCRIPTION COVERAGE CARD IF YOU HAVE ONE ---

Synergy Bariatrics Patient Privacy and Contact Information Form

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Name: _____ DOB: / /

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: _____

Medical History and Health Record

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Today's Date: / /

Name: _____ DOB: / / Age:

Current height: _____ Current Weight: _____ (Date of last measurements: / /) **BMI:**

What is your personal weight loss goal?_____

I have attended the (Circle one):
Recorded Seminar Live Webinar In person Seminar Date of attendance: / /

Please write any questions regarding weight loss surgery (bariatrics/metabolic surgery):

I did understand the material presented (initials: _____)

Which procedure you are interested in (Circle one):
Sleeve Gastrectomy Gastric Bypass (RYGB) band removal revisional surgery Unsure

How did you hear about Synergy Bariatrics?

Have you ever been evaluated for weight loss surgery before? Yes No If yes, who? _____

Have you had prior weight loss surgery? Yes No

If yes, please indicate type of surgery:_____ Date / /

Where was surgery was performed: _____By whom:_____

Highest weight _____ and year _____

What was your lowest weight after the procedure: _____ How many years after the procedure: _____

Was there any adverse events/complications from that procedure?

_____

_____

_____

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PH: 716-565-3990 ○ FAX: 716-565-3988
Hours: Mon-Thurs 8am – 4pm
Fri 8am – 2pm

Name: _____ DOB: / /

Please provide a list of your physicians you have seen over the past 3 years

Speciality	Name	Address	Phone number
Primary Care Physician			
Cardiologist			
Lung doctor (pulmonary)			
Endocrinologist			
Orthopedist			
Kidney doctor (nephrologist)			
Gastroenterologist			
Allergist/ Rheumatologist			
Psychiatrist/psychologist			
Other:			
Other:			

Pharmacy Name:	Pharmacy Phone #: ( )
Pharmacy Address:	City/State:
Insurance Name for Prescription Coverage:	ID/Rx#:
Do you have a mail order pharmacy requirement? If yes, please complete	
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)	Time/s	Reason for taking
If you have more medications; please bring an updated list with you for your appointment			

Name: _____ DOB: / /

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

Include foods, medications, latex, bees, contrast, etc.

Allergen Name	What happened/happens?

Hospitalizations/ Surgeries

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment over the past 5 years. If you need additional room, please continue on the back of this page.

Date	Problem	Hospital/ Facility

Previous Surgeries: Check all that apply (Please write year of surgery)

□ None

□ Heart surgery/ Stents □ Breast Surgery □ Removal of gallbladder

□ Knee replacement □ C-section □ Bowel/intestine Resection

□ Back Surgery □ Vascular Procedure □ Colon Surgery

□ Hysterectomy □ Removal of Appendix □ Hip Replacement

□ Kidney surgery □ Tubal Ligation □ Ovary surgery

□ Hernia (please circle one) Hiatal Inguinal Incisional Umbilical Ventral Other hernia: _____

□ Other (please mention) _____

Have you ever had an adverse reaction to anesthesia/sedation? Y N

(If you answered yes, please comment)

Have any of your relatives had an adverse reaction to anesthesia/sedation? Y N

(If you answered yes, please comment)

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

Type: _____

Name: _____ DOB: / /

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

Cardiac □N/A	□Chest Pain/Coronary Artery Disease/ Angina □Congestive Heart Failure □Irregular/Rapid Heart Beat(arrhythmias) □Peripheral Vascular Disease □Leg Swelling (edema) / Venostasis □Hypertension/High Blood Pressure □Stroke □Blood Clots/Deep Vein Thrombosis □ High Cholesterol, High Triglycerides □ Other:	Gastrointestinal □N/A	□ Gastro Esophageal Reflux (GERD) □ Heartburn □ Stomach/duodenal Ulcers □ Barrett's esophagus □ Crohn's Disease □Ulcerative Colitis □ Frequent Diarrhea □ Frequent Constipation □ Gallbladder Disease □ Fatty Liver □ Hemorrhoids □ Hepatitis(Type): □ Cirrhosis □ Other:
Pulmonary □N/A	□ Sleep Apnea □ Shortness of Breath □ Asthma □ COPD(emphysema, chronic bronchitis) □ Pulmonary Embolism(blood clot in the lungs) □ Pulmonary Hypertension □ Other:	Psychological □N/A	□ Depression □ Bi-Polar Disorder □ Eating Disorder □ Anorexia □ Bulimia □ Anxiety □ Other:
Hematologic □N/A	□ Vitamin D Deficiency □ Anemia □ Bleeding Disorder □ Iron Deficiency □ Other:	Musculoskeletal □N/A	□ Back Pain □ Gout □ Arthritis □ Fibromyalgia □ Other:
Endocrine □N/A	□ Diabetes □ Prediabetes □ Infertility □ Menstrual Irregularities □ Polycystic Ovarian Syndrome (PCOS) □ Thyroid □ Hypothyroidism (Underactive) □ Hyperthyroidism (Overactive) □ Excessive Hot or Cold Feeling □ Changes in your Voice □ Recent Increase in thirst or urination □ Abnormal Hair Growth □ Numbness or Tingling in your Hands/Feet □ Other:	Other □N/A	□ Urinary Stress Incontinence □ Pseudo tumor Cerebri □ Idiopathic intracranial hypertension □ Abdominal Skin/Pannus Irritation/Infection □ Abdominal Wall Hernia □ Kidney Disease □ Kidney Stones □ Seizures □ Migraines □ Psoriasis □ Cancer □ Other:

Name: _____ DOB: / /

Diabetes / Prediabetes –
If you have been diagnosed with or treated for diabetes or Prediabetes, please complete the following section:

Year diagnosed _____

Current form of control:

Diet control only	□ No	□ Yes	
Oral hypoglycemic	□ No	□ Yes	
Insulin	□ No	□ Yes	Number of injections per day_____

Do you have glycosylated hemoglobin (HgA1c) levels tested? □ No □ Yes
If yes, what is your level _____ HgA1c was done _____ ago

Cancer – If you have been treated for cancer, please check all that apply:

□ Breast	□ Endometrial	□ Prostate	□Colon
□ Thyroid	□ Skin	□ Blood	□ Other (name) _____

Year diagnosed _____ Cancer free for _____ years

Treatment received (check all that apply):
□Surgery □ Chemotherapy □ Radiation □ Medication

Sleep Apnea –

Have you ever been diagnosed with Sleep Apnea?	□ Yes	□ No	When: _____
Are you currently on a CPAP Machine?	□ Yes	□ No	
Are you using your CPAP machine every night?	□ Yes	□ No	

Please answer the following if you do NOT have sleep apnea

1- Do you snore loud enough to be heard through closed doors?		□ Yes	□ No
2- Do you often feel tired, fatigued, or sleepy upon waking?		□ Yes	□ No
3- Has anyone observed you stop breathing during your sleep?		□ Yes	□ No
4- Do you have high blood pressure?		□ Yes	□ No
Are you being treated for it?	□ Yes	□ No	
5- Is your Body Mass Index more than 35?		□ Yes	□ No
6- Are you over 50 years old?		□ Yes	□ No
7- Is your neck circumference greater than 17 inches (MEN) or 16 inches (WOMEN)?		□ Yes	□ No
8- Are you a male?		□ Yes	□ No

If you answered more than 4 questions with yes; we strongly advise you to discuss sleep apnea testing with your PCP. Initials: _____

Name: _____ DOB: / /

GERD-Health Related Quality of Life Questionnaire (GERD-HQRL)

Please check the box to the right of each question which best describes your experience over the past 2 weeks

0 = No symptoms;
1 = Symptoms noticeable but not bothersome;
2 = Symptoms noticeable and bothersome but not every day;
3 = Symptoms bothersome every day;
4 = Symptoms affect daily activity;
5 = Symptoms are incapacitating to do daily activities

1. How bad is the heartburn?	□0 □1 □2 □ 3 □4 □5
2. Heartburn when lying down?	□0 □1 □2 □ 3 □4 □5
3. Heartburn when standing up?	□0 □1 □2 □ 3 □4 □5
4. Heartburn after meals?	□0 □1 □2 □ 3 □4 □5
5. Does heartburn change your diet?	□0 □1 □2 □ 3 □4 □5
6. Does heartburn wake you from sleep?	□0 □1 □2 □ 3 □4 □5
7. Do you have difficulty swallowing?	□0 □1 □2 □ 3 □4 □5
8. Do you have pain with swallowing?	□0 □1 □2 □ 3 □4 □5
9. If you take medication, does this affect your daily life?	□0 □1 □2 □ 3 □4 □5
10. How bad is the regurgitation?	□0 □1 □2 □ 3 □4 □5
11. Regurgitation when lying down?	□0 □1 □2 □ 3 □4 □5
12. Regurgitation when standing up?	□0 □1 □2 □ 3 □4 □5
13. Regurgitation after meals?	□0 □1 □2 □ 3 □4 □5
14. Does regurgitation change your diet?	□0 □1 □2 □ 3 □4 □5
15. Does regurgitation wake you from sleep?	□0 □1 □2 □ 3 □4 □5

How often do you experience watery stools or diarrhea?

□ Never or rarely □ Daily □ Weekly

How often do you eat breakfast?

□ Never or rarely □ Daily □ Weekly

Name: _____ DOB: / /

Have you been on any of these medications for heartburn/acid reflux?

Lansoprazole	(Prevacid)	Once a day	Twice a day	Currently Using?	Y	N
Omeprazole	(Prilosec)	Once a day	Twice a day	Currently Using?	Y	N
Pantoprazole	(Protonix)	Once a day	Twice a day	Currently Using?	Y	N
Esomeprazole	(Nexium)	Once a day	Twice a day	Currently Using?	Y	N
Rabeprazole	(Aciphex)	Once a day	Twice a day	Currently Using?	Y	N

Have you been on any of these medications for heartburn/acid reflux?

Omeprazole-Bicarbonate (Zegerid)	Once a day	Twice a day	Currently Using?	Y	N
Dexlansoprazole (Dexilant)	Once a day	Twice a day	Currently Using	Y	N
Cholestyramine (Colestid)	Once a day	Twice a day	Currently Using?	Y	N
Zantac (Ranitidine)	Once a day	Twice a day	Currently Using?	Y	N
Pepcid (Famotidine)	Once a day	Twice a day	Currently Using?	Y	N

Social history:

Marital Status: □ Single □ Married □ Divorced since _____ □ Widowed since _____

Who lives with you?

Current occupation? □ Full-time □ Part-time

Are you on disability?
If so, since when and for what reason?

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 chew tobacco □ Yes □ No

Do you use / have used chewing tobacco, electronic cigarette or vaping? □ Yes □ No

Drug Use: □ Cocaine □ Crack □ Heroin □ Recreational Marijuana □ Medicinal Marijuana
If you use medicinal Marijuana, Who prescribe it:_____ is it □ smoked/inhaled or □ eatable/drops
Other (please list): _____

Alcohol history:
- □ I never drank.
- □ I am a former drinker having quit on _____ after _____ years.
- □ I am currently drinking (beer, wine, liquor) How frequent?

I understand that I must be nicotine and drug free for 2 months before surgery initials_____

Name: _____ DOB: / /

Do any of your immediate family members suffer from the following conditions?		
Condition		**Family Member**
Obesity	□	
Diabetes	□	
Blood Clots	□	
Bleeding Tendency	□	
Stroke	□	
Heart Disease	□	
Heart Attack	□	
Pulmonary Embolism	□	
Problems with anesthesia	□	
Cancer, list type	□	

Have you had any of the following Diagnostic Studies done in the past 2 years (please attach reports, if possible)			
□	Upper endoscopy (EGD)	□	Stress test
□	Colonoscopy	□	Echocardiogram
□	Ultrasound abdomen	□	Heart catheterization
□	CT scan abdomen/pelvis	□	Pulmonary function test (PFT)
□	Mammogram	□	Upper GI study (Barium swallow)
□	Other:		

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**
		Current Birth control:			
Men only:		□	**Erectile dysfunction**	□	**Prostate problems**

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

Signature: _____Date:_____

Weight Loss/Diet History

PLEASE MAIL THIS FORM TO SYNERGY BARIATRICS

Name: _____ DOB: _____

Highest adult weight: _____at age_____Lowest adult weight:_____ at age_____

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 AND MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS

Synergy Bariatrics
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Fri 8am – 2pm

Stamp Physician Name and Address

Primary Care Physician Documentation for Bariatric Surgery Approval

BRING THIS TO YOUR PRIMARY CARE DOCTOR

Please fax completed form with most recent visit notes and labs to (716) 565-3988

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 with most recent visit notes and labs to (716) 565-3988

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