Trinity Bariatric Institute, PLLC

Dr. David Dyslin

9718 North Beach Street Ste. 204 Fort Worth, TX 76244
P: 817-832-7227 F: 817-740-2259

General Surgery Medical History Form

Last Name: _____ First: _____ MI: _____ Age: _____

DOB: _____ Sex: _____ SS#_____ Marital Status: _____

Home address: _____
Street Apt#/Bldg# City State Zip Code

Mailing address: _____
Street Apt#/Bldg# City State Zip Code

Home phone: _____ Work phone: _____ Cell phone: _____

E-mail address: _____ May we contact you via email? _____

Occupation: _____ Employer: _____

Employer's address: _____
Street Apt#/Bldg.# City State Zip Code

How did you hear about us?

- ☐ Facebook
- ☐ Website
- ☐ Internet Search
- ☐ Instagram
- ☐ Physician Referral
- ☐ Family/Friend
- ☐ Employer
- ☐ Hospital
- ☐ Insurance company
- ☐ Magazine
- ☐ Radio
- ☐ Post Card
- ☐ ER
- ☐ Other Bariatric Center
- ☐ Yelp
- ☐ Other _____

Reason for visit: _____

Referring physician's name: _____

Phone: _____ Fax: _____

Primary care physician's name: _____

Phone: _____ Fax: _____

Trinity Bariatric Institute, PLLC

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PAST MEDICAL HISTORY: (Please check all that apply and list details/diagnoses)

- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Coagulation Disorder (Taking Plavix or Coumadin)
- ☐ Diabetes (Type: __I or __II)
- ☐ Emphysema/COPD
- ☐ Pulmonary Embolism
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ DVT
- ☐ Cancer _____
- ☐ Other_____

PHARMACY NAME: _____

Address: _____

Street City State Zip Code

Phone: _____

MEDICATIONS: Prescription and non-prescription

Medication Name	Dose	Times per day

SURGICAL HISTORY: (Including colonoscopy, defibrillator, pacemaker, and stents)

___Hysterectomy ___Gallbladder ___Hernia ___Appendix ___Tonsillectomy

Type of surgery	Date

ALLERGIES: ___None ___PCN ___Sulfa ___Latex ___Tape

___ Iodine/Dye ___ Surgical Glue ___Nickel ___Other Metals

Medication Allergic To	Reaction/Side Effect

SOCIAL HISTORY

Cigarettes: ___ Never ___ Current smoker: packs/day ____ # of years _____

___Quit: (Date_____, and how many years did you smoke ____)

Other tobacco use (please specify): _____

Alcohol use: ___ No ___ Yes: # drinks/week and type _____

Recreational drug use: __ N/A __Marijuana __Cocaine __Meth __Other_____

FAMILY HISTORY: (Please check all that apply)

Medical Condition	Dad	Mom	Sister	Brother	Grandmother	Grandfather	Other
Asthma							
Bleeding disorder							
Blood Clots/DVT							
Breast Cancer							
Colon Cancer							
Melanoma							
Thyroid Cancer							
Parathyroid Cancer							
Diabetes Mellitus							
Heart Attack							
High blood pressure							
Kidney Disease							
Leukemia							
Lupus							
Lymphoma							
Stroke							
Vascular Disease							

REVIEW OF SYSTEM: (Please check all symptoms you are experiencing)

General Constitutional	**Yes**
Fatigue	
Fever	
Heavy lifting at work	
Recent weight change	
Eyes and vision	**Yes**
Blurred or double vision	
Cataract	
Eye disease or injury	
Glaucoma	
Wear glasses or contact lenses	
ENT	**Yes**
Bleeding gums	
Hearing loss	
Ringing in the ears	
Sinus problem	
Sore throat or voice change	
Swollen glands in neck	
Musculoskeletal	**Yes**

Back pain	
Cold extremities	
Difficulty in walking	
Joint pain	
Joint stiffness or swelling	
Muscle pain or cramps	
Weakness of muscles/joints	
Skin and Breasts	**Yes**
Breast discharge	
Breast lump	
Breast pain	
Change in hair or nails	
Change in skin color	
Rash or itching	
Varicose veins	
Neurological	**Yes**
Convulsions or seizures	
Frequent or recurrent headaches	

Light headed or dizzy	
Numbness or tingling sensations	
Paralysis	
Heart and Cardiovascular	**Yes**
Chest pain	
Irregular heartbeat	
Swelling in feet, ankles, hands	
Respiratory	**Yes**
Asthma or wheezing	
Frequent coughing	
Shortness of breath	
Gastroenterologist	**Yes**
Change in bowel movements	
Constipation	
Frequent diarrhea	
Heartburn/GERD	
Loss of appetite	
Nausea and vomiting	
Genitourinary	**Yes**
Blood in urine	
Burning or painful urination	

Frequent urination	
Incontinence	
Irregular period	
Kidney stones	
Psychiatric	**Yes**
Anxiety	
Depression	
Sleeping difficulty	
Endocrine	**Yes**
Diabetes	
Excessive thirst or urination	
Heat or cold intolerance	
Thyroid disease	
Hematologic/Lymphatic	**Yes**
Anemia	
Easily bruise or bleed	
Phlebitis	
Slow heal after cuts	
Swollen glands	
Transfusion	

I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO TRINITY BARIATRIC INSTITUTE AND MY REFERRING PHYSICIANS

Patient Signature: _____ **Date:** _____

Trinity Bariatric
INSTITUTE
David Dyslin, MD, FACS, FASMBS
9718 North Beach Street, Suite 204, Fort Worth, Texas 76244
Phone: 817-832-7227 Fax: 817-740-2259

Release of Information Request

Patient's Name: _____ Maiden/Former Name: _____

Patient's Address: _____

City, State, ZIP: _____

Birth Date: _____ Social Security #: _____

Home Phone: _____ Other Phone: _____

I, Authorize:
Name: _____
Address: _____
Phone: _____

To Release To:
Trinity Bariatric Institute

The following information may be released:

- ☐ Entire Medical Record
- ☐ Specific Record From _____ to _____
- ☐ Immunizations
- ☐ Billing Record
- ☐ Other _____

Purpose of Disclosure:

- ☐ Medical Care
- ☐ Insurance
- ☐ Attorney
- ☐ Other _____

I consent to the release of the indicated sensitive, legally protected records:

_____ Mental Health Records _____ Chemical Dependency
_____ HIV or AIDS _____ Genetic Testing

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name Relationship to Patient

I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected. 09/2012

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX MM / DD / YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___)_____ Day Phone: (___)_____ Email: _____

Race_____ Language_____ Ethnicity ❒ Hispanic/Latin ❒ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX MM / DD / YY DATE OF BIRTH AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____ (___) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ ___ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ ___ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accord-ingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date #_____

_____ _____

Date *Patient/Legal Representative*

THCOBP12

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Print Name

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Texas Health Care, P.L.L.C.

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - o OK to leave a message with detailed information
  - o Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - o OK to leave message with detailed information
  - o Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

_____

Patient Signature (Must be an adult 18yrs or older) Date

_____

Print Name Birthdate

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the practice team liaison in this office.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing,.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:
L. Timothy Knutson
Texas Health Care
2821 Lackland Road, Suite 300
Fort Worth, TX 76116
(817) 740-8400
ltknutson@thsmso.com

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.