Ronnie Keith,D.O. FACOS
2405 Palmer Circle
NORMAN, OK 73069
Phone: (405) 360-7100 Fax:(405) 364-9112
www.drkwellness.com

Thank you for your interest in our surgical weight loss program. You could be a potential candidate for weight loss surgery if you are:

- Approximately 100 lbs or more overweight
- Suffering from complications of obesity
- Well informed and well motivated
- Unable to sustain non-surgical weight loss

Our program is unique in both pre-surgical evaluations and after surgery support:

EVALUATIONS: Medical/Surgical - Psychological - Dietary
COUNSELING: Nutrition - Physical Performance - Behavioral
EDUCATION: Seminars - Patient Manual - Pre-Operative Class
LONG TERM SUPPORT: Support Groups - Physician Follow-up

SURGICAL TREATMENT FOR MORBID OBESITY IS A SERIOUS UNDERTAKING which will require a change of lifestyle in many ways. We wish to offer this treatment option to those patients most likely to benefit.

Please bring the following with you to your appointment:
□ **Photo ID**
□ **Insurance Cards**
□ **Patient Packet**

If you have any questions or need to reschedule or cancel your appointment please call our office.

Thank you again for your interest in our program!

Dr. Keith's
WELLNESS OPTIONS

PATIENT INFORMATION SHEET

PATIENT NAME:_____ DATE OF BIRTH:_____

AGE:_____ SS#_____ MARITAL STATUS: M S D W SEX: M F

RACE:_____ PREFERRED LANGUAGE:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

HOME:_____ CELL:_____ WK:_____

EMAIL:_____PLACE OF EMPLOYMENT:_____

EMERGENCY CONTACT:_____PHONE:_____

RELATIONSHIP:_____

HOW DID YOU HEAR ABOUT US: **TV** **INTERNET SITE:**_____ **FRIEND/FAMILY:**_____

OTHER:_____

REFERRING / FAMILY PHYSICIAN INFORMATION:

REFERRING / FAMILY PHYSICIAN:_____PHONE:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PREFERRED PHARMACY INFORMATION:

PHARMACY NAME:_____PHONE:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____

ID#:_____GROUP#:_____

SUBSCRIBER'S NAME:_____SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____SUBSCRIBER'S SEX: M F

ADDRESS:_____CITY_____STATE_____ZIP_____

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

SECONDARY INSURANCE COMPANY:_____

ID#:_____GROUP#:_____

SUBSCRIBER'S NAME:_____SUBSCRIBER'S SS#_____

SUBSCRIBER'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____SUBSCRIBER'S SEX: M F

ADDRESS:_____CITY_____STATE_____ZIP_____

SUBSCRIBER'S PLACE OF EMPLOYMENT:_____

INSURANCE IS NOT A GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.

FINANCIAL AGREEMENT"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE:_____**DATE:**_____

Let's begin collecting information to support your decision to have weight loss surgery. Our program and your insurance provider want to review your attempts to lose weight in the past. It is important to review your attempts, successes and maybe not successful, as we structure an individualized program for you.

Please complete this as accurately as you can recall and date and sign.

WEIGHT LOSS ATTEMPTS

PROGRAM (circle all weight loss attempts)	PROGRAM DATES	BEGINNING WEIGHT	ENDING WEIGHT	HOW LONG TO REGAIN?	PHYSICIAN SUPERVISED? Y/N	DIETITIAN SUPERVISED? Y/N
Weight Watchers						
Jenny Craig						
Nurisystem						
Atkins						
South Beach						
HCG						
<u>Prescribed Medications:</u> Phentermine Fen/Phen Qsymia Belviq Contrave Meridia Xenical						
Over The Counter Diet Pills _____						
Herbalife Plexus Zeal Slimfast						
Hypnosis Jaw Wiring Acupuncture						
Others _____ _____						

Signature _____ **Date** _____

Dr. Keith's
WELLNESS OPTIONS

BARIATRIC MEDICAL QUESTIONNAIRE

Please list **ALL** health care providers seen in the last 5 years

OK FOR US TO NOTIFY THE PHYSICIAN?

1. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT : _____

2. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT : _____

3. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT : _____

4. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

5. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT : _____

6. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT : _____

Have you had previous **Weight Loss Surgery?** If yes, complete below:

Date of Previous Weight Loss Surgery: _____

Surgeon/Address: _____

_____

Type of Procedure:

Gastric Bypass (Roux-en-Y), Laparoscopic
Gastric Bypass (Roux-en-Y), Open
Gastric Bypass, banded
Vertical Banded Gastroplasty
Gastric Band, adjustable
Gastric Band, non-adjustable
Biliopancreatic Diversion
Sleeve Gastrectomy
Other _____

Original Weight _____ **Lowest Weight Achieved**_____

SURGICAL HISTORY

Please circle and list year or exact date if known

_____Appendectomy
_____Back
_____Breast Cancer
_____Cancer (any type)
_____C-Section
_____Colon/Intestinal Surgery
_____Gallbladder
_____Hemorrhoids
_____Heart
_____Hernia (hiatal)
_____Hernia (umbilical)
_____Hernia (inguinal)
_____Hernia (ventral)
_____Knee
_____Lung
_____Ovaries
_____Prostate
_____Thyroid
_____Tonsillectomy
_____Tubal Ligation
_____ Ulcers, Stomach
_____Uterus Hysterectomy
_____Colon Scope
_____Stomach Scope
_____Other (Please explain)
_____
_____

FAMILY HISTORY

*Please **SPECIFY** which family member has the below co-morbidities:*
(Grandparents, Parents, Siblings, and Children only)

Diabetes_____
High Blood Pressure_____
Heart Attack(s) _____
Stroke_____
Obesity_____
High Cholesterol_____
Depression_____
Bleeding Disorder_____
Psychiatric Illness_____
Cancer-If so, What kind(s)?_____

Dr. Keith's WELLNESS OPTIONS

MEDICATIONS

Include prescribed and non-prescription medicines you are currently taking; vitamins, "natural remedies", aspirin, Tylenol, cold meds, etc.

NAME_____ **Date of Birth**_____

Allergies:

Reaction Types

1 (Minor rash or nausea)
2 (Severe rash or vomiting)
3 (Difficulty breathing or shock)

Name of Allergen	Reaction Type	Name of Allergen	Reaction Type

Medications you are currently taking

Name of Medication	Strength	How Often Taken	Reason	Start Date

Please use separate sheet to continue list if needed

Dr. Keith's
WELLNESS OPTIONS

HEALTH HISTORY

Please check those that apply and include diagnosis date

Hypertension/High Blood Pressure-*Date Diagnosed:*_____
( ) No history of high blood pressure
( ) I have high blood pressure, no medication
( ) Treatment with one medication
( ) Treatment with multiple medications

Congestive Heart Failure (CHF)- *Date Diagnosed:*_____
( ) No history or symptoms of CHF
( ) Diagnosed with CHF

Heart Disease -*Date Diagnosed:*_____
( ) No history of heart disease
( ) Abnormal EKG
( ) History of heart attack
( ) Stent placement, or bypass

Lower Extremity Swelling -*Date Diagnosed:*_____
( ) No symptoms of lower extremity swelling
( ) Occasional lower extremity swelling,
Not requiring treatment
( ) Stasis ulcers
( ) Disability, decreased function

DVT/PE (Blood clot in legs or lungs) -*Date Diagnosed:*_____
( ) No history of DVT/PE
( ) History of DVT resolved with anticoagulation
( ) Recurrent DVT long term anticoagulation meds
( ) Previous PE
( ) Recurrent PE, decreased function, hospitalization
( ) Vena Caval filter

Diabetes-*Date Diagnosed:*_____
( ) No symptoms of diabetes
( ) Elevated fasting blood sugar
( ) Diabetes, controlled with medication by mouth
( ) Diabetes, controlled with insulin
( ) Diabetes, controlled with insulin and oral
Medication
( ) Diabetes, with severe complications
(retinopathy, neuropathy, renal failure)

Cholesterol-*Date Diagnosed:*_____
( ) Not present
( ) Present, no treatment required
( ) Controlled with lifestyle change
( ) Controlled with single medication
( ) Controlled with multiple medications
( ) Not controlled

Gout-*Date Diagnosed:*_____
( ) No symptoms of gout
( ) Present, requiring medications
( ) Disability, unable to walk

Obstructive Sleep Apnea- *Date Diagnosed:*_____
( ) No symptoms or evidence of OSA
( ) Sleep apnea symptoms (Negative sleep study)
( ) Sleep apnea by sleep study, No CPAP required
( ) Sleep apnea requiring CPAP and I am using
( ) Sleep apnea requiring CPAP and I am NOT using

Asthma- *Date Diagnosed:*_____
( ) No symptoms of asthma
( ) Occasional mild symptoms, no medication
( ) Symptoms controlled with oral inhaler
( ) Well controlled with ongoing daily medication
( ) Symptoms not well controlled
( ) Hospitalized within last 2 years, history of intubation

Reflux -*Date Diagnosed:*_____
( ) No history of reflux
( ) Occasional symptoms, no medication
( ) Medication as needed
( ) Meds everyday
( ) Meet criteria for anti-reflux surgery, or prior
Surgery for GERD

Gallstones -*Date Diagnosed:*_____
( ) No history of gallstones
( ) I have Gallstones
( ) History of gallbladder removal

Liver Disease -*Date Diagnosed:*_____
( ) No history of liver disease
( ) Enlarged liver, Normal Liver function
( ) Enlarged liver, Abnormal Liver function
( ) Cirrhosis, Hepatitis
( ) Liver failure, transplant indicated or done

Back Pain -*Date Diagnosed:*_____
( ) No symptoms of back pain
( ) Occasional symptoms not requiring treatment
( ) Symptoms requiring non-narcotic treatment
( ) Degenerative changes requiring narcotic treatment
( ) I have had surgery or recommended; pending weight loss
( ) Failed previous surgery with existing symptoms

Joint Pain -*Date Diagnosed:*_____
( ) No symptoms of Joint Pain
( ) Pain with ambulation
( ) Non narcotic medication required
( ) Narcotic medication required
( ) Awaiting or past joint replacement

Dr. Keith's
WELLNESS OPTIONS

HEALTH HISTORY

Please check those that apply and include diagnosis date

Fibromyalgia -*Date Diagnosed:*_____
( ) No history of fibromyalgia
( ) Treatment with exercise
( ) Treatment with non-narcotic medications
( ) Treatment with narcotics
( ) Disabling, treatment not effective

Polycystic Ovarian Syndrome -*Date Diagnosed:*_____
( ) No history of PCOS
( ) Symptoms of PCOS, no treatment
( ) Birth control for treatment of PCOS
( ) Metformin for treatment of PCOS
( ) Combination therapy
( ) Infertility

Confirmed Mental health diagnosis -*Date Diagnosed:*_____
( ) None
( ) Bipolar Disorder
( ) Anxiety/panic Disorder
( ) Personality disorder
( ) Psychosis

Depression-*Date Diagnosed:*_____
( ) No symptoms of depression
( ) Mild, not requiring treatment
( ) Moderate with significant impairment
Treatment indicated
( ) Severe, definitely requiring intensive
Treatment
( ) Severe requiring hospitalization

Alcohol Use
( ) None
( ) Rare
( ) Occasional
( ) Frequent

Substance Abuse (Prescription or Illegal Drugs)
( ) None
( ) Rare
( ) Occasional
( ) Frequent

Tobacco and/or Nicotine Use
( ) None
( ) Former Smoker, Quit_____
( ) Rare
( ) Occasional
( ) Frequent_____pack per day for_____years
( ) E cig or Vaping
( ) Dip

Stress Urinary Incontinence-*Date Diagnosed:*_____
( ) No history of stress urinary incontinence
( ) Minimal and occasional
( ) Frequent but not severe
( ) Daily occurrence, requires pad
( ) Disabling
( ) Operation ineffective

Abdominal Hernia-*Date Diagnosed:*_____
( ) No Hernia
( ) Hernia, no prior operation
( ) Successful repair of hernia
( ) Recurrent hernia
( ) Multiple failed hernia repairs

Functional Status-*Date Diagnosed:*_____
( ) No impairment of functional status
( ) Able to walk 200 ft with assistance device
( ) Cannot walk 200 ft with assistance device
( ) Requires wheelchair
( ) Bedridden

Abdominal Skin-*Date Diagnosed:*_____
( ) No symptoms
( ) Irritation/Rash in skin folds
( ) Abdominal Skin so large it interferes with ambulation
( ) Recurrent cellulitis, ulceration
( ) Surgical treatment required

Please list all other medical conditions below and include diagnosis date:

_____

_____

_____

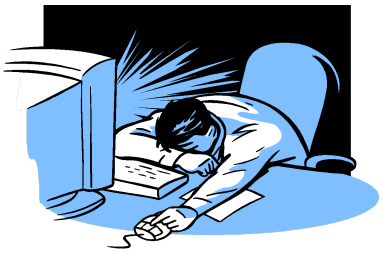
_____

_____

_____

_____

IT HAS BEEN PROVEN THAT 1 IN EVERY 3 AMERICANS SUFFER FROM A SLEEP DISORDER



Complete the following quiz and score yourself at the bottom.

( ) 1. I have been told that I snore
( ) 2. I have been told that I stop breathing while I sleep
( ) 3. I have gained weight
( ) 4. I suffer from high blood pressure
( ) 5. I feel fatigued during the day
( ) 6. I suffer from morning headaches
( ) 7. I have lost interest in sex
( ) 8. I sweat excessively during the night
( ) 9. I suddenly wake up unable to breathe
( ) 10. My family and friends say that they have noticed a change in my personality

( ) 11. I have been told that I kick in my sleep
( ) 12. I experience a “creepy, crawly” sensation in my legs
( ) 13. I have excessive daytime drowsiness
( ) 14. I have been told that I am a restless sleeper
( ) 15. I awaken with sore or achy muscles
( ) 16. I often have trouble staying asleep throughout the night

( ) 17. I have fallen asleep while driving
( ) 18. I experience vivid nightmares soon after falling asleep
( ) 19. No matter how hard I try to stay awake, I fall asleep
( ) 20. I fall asleep throughout the day
( ) 21. I feel paralyzed when I am waking up or falling asleep
( ) 22. I feel like I am hallucinating when I fall asleep

( ) 23. I feel afraid to go to sleep
( ) 24. I have trouble falling asleep
( ) 25. Thoughts run through my mind, preventing me from going to sleep
( ) 26. It often takes me an hour or more before I fall asleep
( ) 27. I wake up in the middle of the night unable to return to sleep

SCORES

Sleep Apnea is a life threatening sleep disorder which frequently causes you to stop breathing. It can happen hundreds of times per night while you sleep and you may not even be aware it is happening.

Place the number checked from each of the following sections in the space provided below.

_____ Questions 1-10
_____ Questions 11-16
_____ Questions 17-22
_____ Questions 23-27

PATIENT EMAIL CONSENT

Name: _____

Address: _____

E-mail: _____

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender of the recipient has deleted his or her copy.
d) Employers and on-line services have the right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF MAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will be printed and filed in the patient's medical record.
d) Office staff may receive and read your messages.
e) The patient should not use email for communication regarding sensitive medical information.
f) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patients by email. If I have any questions I may inquire with my treating physician or the Office Manager.

Patient Signature: _____Date: _____

HIPAA
CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ Date of Birth: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

NORMAN OFFICE:
(405) 360-7100
2405 Palmer Circle
Norman, OK 73069

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

My information may be released to the following organizations and/or individuals:

_____

_____

SIGNATURE SECTION – PLEASE PRINT

I, _____, have had full opportunity to read and consider the consents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____