Sidney P. Rohrscheib, M.D.

Thank you for your interest in the Illinois Bariatric Center. Should surgery be the best approach to managing your weight, we guarantee our commitment to personalized and quality care. Our physicians, nurses, dieticians and staff prepare patients carefully before surgery. We believe this comprehensive preparation helps us meet your expectations after surgery.

Please carefully complete the enclosed sheets and bring them, along with any insurance information, to your initial consult. It is our goal to make this process as easy and trouble-free as possible. If you have questions that are not answered in this information, please do not hesitate to call us.

We now have 3 locations in Illinois to serve you better!

Illinois Bariatric Center – Champaign/Savoy
411 Clarendon Court, Suite 101
Savoy, IL 61874
(217) 693-5700

Illinois Bariatric Center – Clinton
803 Illini Drive
Clinton, IL 61727
(217) 935-7037

Illinois Bariatric Center – Robinson
Crawford Memorial Hospital Consulting Clinic
1000 N. Allen Street
Robinson, IL 62545
(217) 935-7037

SIDNEY ROHRSCHEIB, MD
PATIENT REGISTRATION

Date: _____

Patient: _____
(First) *(Middle Initial)* *(Last)*

Preferred Name: _____ **Sex:** Male ☐ Female ☐

Phone: _____ E-mail Address: _____

Mailing Address: _____ City:_____

State:_____Zip:_____ Is your mailing address different than your street address? Yes ☐ No ☐

Birth Date**:** _____ Age: _____ Patient SS#: _____

Race: White ☐ African American ☐ Hispanic ☐ American Indian ☐ Pacific Islander ☐ Asian ☐ Other ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner ☐

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

PRIMARY INSURANCE COVERAGE

Policyholder: _____ Relationship to Patient:_____

Insurance Company: _____ Policyholder's Date of Birth: _____

SECONDARY INSURANCE COVERAGE

Policyholder: _____ Relationship to Patient:_____

Insurance Company: _____ Policyholder's Date of Birth:_____

Emergency Contact: _____ Relation: _____ Phone:_____

Primary Care Physician: _____ Pharmacy Name: _____

Pharmacy Address: _____ Phone: _____

How did you hear about us? _____

Please read and initial where indicated

CONSENT TO TREAT

_____ I hereby authorize employees and agents; include physicians, physician assistants, nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form, obtain medical history, and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physician's choice.

_____ I consent to having my picture taken for chart monitoring purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA NOTICE OF PRIVACY PRACTICES

_____ Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information and of other matters about your health information. It also describes your rights to access and control your protected health information. A copy of our Notice is posted in our office and available on our website.

I give my permission to release my medical information and lab results to the following persons:

Name	Relationship
_____	_____
_____	_____

FINANCIAL AGREEMENT

- It is your responsibility to inform our office of any address, telephone number or insurance changes. You may be responsible for additional charges if your primary insurance is terminated during your medical care.
- Your account is to be kept current- accordingly all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service.
    - Past due accounts will be assigned to a collection agency; if you are concerned about the status of your account or would like to discuss it with our Office Manager, please let us know.
    - If your account is turned over to a collection agency, you will be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fee of 33% of the balance.
- We will submit your insurance claims. However, **WE MUST EMPHASIZE THAT AS MEDICAL PROVIDERS, OUR RELATIONSHIP IS WITH YOU <u>NOT</u> YOUR INSURANCE COMPANY.** We attempt to verify your benefits but encourage you to do the same.
    - Not all services are a covered benefit with all insurance plans.
    - It is YOUR responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
    - You are responsible for any non-covered charges not payable by your insurance company
    - Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility.
    - We realize that temporary financial problems may affect timely payment; we urge you to contact us promptly for assistance should a problem arise.

NOTICE REGARDING COMMUNICATION

IBC staff may contact patients via phone, email, and/or text messaging to remind you of an appointment, financial/insurance information, or to provide general health reminders and information.

_____ I authorize Illinois Bariatric to leave detailed messages pertaining to **medical information including test results, instructions regarding treatment, medications, & billing and financial questions** on my **voicemail/answering** machine.

_____ I authorize Illinois Bariatric to **email** me with **appointment details and reminders** at the email address I have provided for contact.

_____ I authorize Illinois Bariatric to **text** me with **appointment details and reminders**. Sharing of clinical information via text message is not recommended, IBC prefers you to contact the office directly with any questions/concerns.

We are happy to communicate with you electronically regarding appointment times, status checks, etc. We are working constantly to ensure our network is safe, but please be aware, if our network or email systems were to ever be breached your private health information could be accessed & viewed by unauthorized persons. If you do not consent to electronic communications, please notify the office.

The above information is accurate and complete to the best of my knowledge and I authorize release of information to obtain precertification for surgery and file a claim with my insurance company. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date:_____

SIDNEY ROHRSCHEIB, MD
MEDICAL INFORMATION

Name: _____ Date:_____

Do you have or have had any of the following (check all that apply)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Have you had sleep study?
- ☐ Sleep Apnea, CPAP ☐ BiPAP ☐
- ☐ Reflux or Heartburn
- ☐ Degenerative Joint Disease/Arthritis
- ☐ Blood Clots in Legs or Lung
- ☐ Asthma
- ☐ Shortness of Breath with Activity
- ☐ Lung Disease
- ☐ Gallbladder or Liver Disease
- ☐ Leg/Ankle Swelling
- ☐ Hip, Back or Knee Pain
- ☐ Stroke
- ☐ Pancreatitis
- ☐ Cancer
- ☐ Ulcers, Where? _____
- ☐ Crohns Disease, Colitis
- ☐ Hernia
- ☐ Urine Incontinence
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Anorexia/Bulimia
- ☐ Laxative Use for Weight Loss
- ☐ Infertility
- ☐ Menstrual Irregularities
- ☐ Polycystic Ovarian Syndrome
- ☐ Skin Fold Irritation/Yeast Infections

Family History **Who?**

- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Heart Disease _____
- ☐ Asthma or Lung Disease _____
- ☐ Gallbladder or Liver Disease _____
- ☐ Other _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Depression _____
- ☐ Arthritis _____
- ☐ Diabetes _____

Previous Surgeries: Date:

Allergies to medication or latex? (If yes, what type of reaction do you have?)

Do you use smoke/vape? _____ If so, how much?_____ for how long? _____
Do you drink any alcoholic beverages? _____ If so, how much?_____ how often? _____
Do you or have you used illicit drugs? ____ If so, what? _____
How much? _____ How long? _____

Patient Name: _____ Date of Birth: _____ Pharmacy: _____

ALLERGIES: _____ CPAP USE: YES ☐ NO ☐

At each visit please mark box with a ✓ if medication is current or cross through the box with a line if stopped

MEDICATION & DOSAGE (Mg)	REASON	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	APPOINTMENT DATE	
Reviewed by:														

ILLINOIS BARIATRIC CENTER
PHYSICIAN LIST

Name: _____ Date:_____

List information on your current primary care physician and **ALL previous physicians within the past 3 years**.

PHYSICIAN NAME	SPECIALTY	CITY	PHONE #	FAX #
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ILLINOIS BARIATRIC CENTER
DIET HISTORY

Name: _____ Date: _____

Current Weight: _____ Goal (Desired) Weight: _____

Height: _____ Weight at age 18: _____

1. **Record ALL weight loss attempts within the past 5 years**, *especially professionally supervised (physician and/or registered dietitian) programs*. Also, be sure to list attempts that were not professional supervised. Do NOT leave this sheet blank.
2. Start with most recent diet and work backward from there. You may make additional copies or use another sheet.
3. If you were on weight loss medications, what type of food plan were you following (low fat, 1,200 calorie, etc.) in addition to taking the drug?

TYPE/NAME OF DIET	YEAR	LENGTH OF TIME ON DIET	IF SUPERVISED, NAME OF DOCTOR OR DIETITICIAN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			