Female Patient Registration Form

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Patient Information:

Patient/Child First Name:_____ MI:_____ Last Name:_____

Age:_____ Date of Birth:_____ Occupation:_____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widow/widower ☐ Divorced Soc. Sec. #:_____

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Email address:_____ Drivers License #:_____

Primary Care Provider:_____

Referring Doctor:_____

Parent/Guardian (REQUIRED IF PATIENT IS UNDER 21 YEARS):

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is NOT bound by any separation agreement, divorce or child support order.

Parent/Guardian:_____ Birth Date:_____

Address (if different from above):_____

Social Security # (required):_____ Employer: _____

Preferred Phone #: _____

In case of an emergency, who would you like to be contacted?

Contact Name:_____ Relationship to Patient:_____

Home Phone #:_____ Work Phone #: _____

By signing, you agree the information above is correct and give permission for Lamond Family Medicine and Blue Sky to file claims on your behalf.

HIPAA CONSENT: Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below. (leave blank if you would not like any additional individuals to have information regarding your care.

1. _____ Patient/Guardian Signature: _____

2. _____ Date: _____

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1287 Creekshire Way | Winston-Salem, NC | 336.245.9521

Please print this form to bring to your appointment, or you can email it to info@blueskymd.com

Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to both LaMond Family Medicine and Blue Sky MD.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment if necessary. Please allow 24 hrs for a response to refill requests. Samples are given at scheduled appointments ONLY and can ONLY be given by the doctor.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

Patient/Guardian Signature for Financial and Office Policies: _____

(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.
UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.
YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.
OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.
OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.
FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature: (HIPAA Policy) _____ Date:_____

REMINDER: Please bring a current copy of your mammogram and pap smear (within the last 12 months) to your initial consultation.

Please print this form to bring to your lab appointment, or you can email it to info@blueskymd.com.

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Health History

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Personal Health History:

Name:_____ Primary/Referring Physician:_____

Date:_____ Height:_____ Weight:_____ Age:_____

List any medical problems that other doctors have diagnosed:

Year:	Medical Problem:	Treatment/Medication(s): *(if prescribed)*

Surgeries:

Year:	Type of Surgery:	Surgery Reason:

List your prescribed drugs, over the counter medications and supplements

Name of Drug:	Strength:	Frequency Taken:

Allergies to medications:

Name of Drug:	Reaction:

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Health Habits

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise: (check your selection) ☐ Sedentary (no exercise) ☐ Lightly active (1-3 days per week)
☐ Moderately Active (3-5 days per week) ☐ Very Active (6-7 days per week)

☐ Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ None _____ # of cups/cans per day?

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____

How many drinks per week? _____ Are you concerned about the amount you drink ☐ Yes ☐ No

Do you Use Tobacco? ☐ Yes ☐ No Cigarettes (packs/day): _____ Chew (#/day): _____

Pipe (#/day): _____ Cigars (#/day): _____ # of years: _____ Year quit: _____

Family Health History: (Please comment on general, weight and psychiatric history)

	Age	Significant Health Problems
Father:	_____	_____
		_____
Mother:	_____	_____
		_____

Children:

How many children: _____ Ages: _____ _____ _____ _____ _____ _____

	M/F	Age	Significant Health Problems
Sibling:	_____	_____	_____
Sibling:	_____	_____	_____
Sibling:	_____	_____	_____
Sibling:	_____	_____	_____

	Age	Significant Health Problems
Grandmother (Maternal):	_____	_____
Grandfather (Maternal):	_____	_____
Grandmother (Paternal):	_____	_____
Grandfather (Paternal):	_____	_____

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Mental Health

Have you ever been diagnosed or treated for Depression and/or Anxiety? ☐ Yes ☐ No

Have you ever been diagnosed or treated for an Eating Disorder (ie: anorexia/bulimia)? ☐ Yes ☐ No

Do you panic when stressed? ☐ Yes ☐ No

Do you have problem with your appetite when under stress? ☐ Yes ☐ No

Do you cry frequently? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Have you ever been to a counselor? ☐ Yes ☐ No

Mark by and describe (if needed) any significant symptoms you suffer from in the following areas:

☐ General (fatigue, night sweats, unexplained weight change) _____

☐ Eyes (visual trouble, trouble with eye pressure, eye redness/discharge) _____

☐ Ears (difficulty hearing, ringing in the ears) _____

☐ Nose (chronic discharge/drainage) _____

☐ Throat (sore throat) _____

☐ Lungs (wheeze, shortness of breath, snoring, asthma, wake gasping for breath) _____

☐ Chest/Heart (chest pain, palpitations, irregular heartbeat, hx rheumatic fever) _____

☐ Hematology (easy bruising, trouble with blood clotting, nose bleeds, miscarriage) _____

☐ Stomach/GI (abdominal pain, nausea, vomiting, heartburn/reflux) _____

☐ Bladder (kidney stones, urinary frequency, blood in urine, prostate problems) _____

☐ Bowel (blood in stool, constipation, diarrhea, change in stool) _____

☐ Circulation (varicose veins, leg swelling/edema) _____

☐ Musculoskeletal (back pain, joint pains, leg pain) _____

☐ Neurology (headaches, dizziness, passing out, migraine, stroke) _____

☐ Allergy (hives, rash, itching) _____

☐ Sleep (Trouble falling asleep, staying asleep, snoring, never feel rested) _____

☐ Psychiatric (depression, anxiety, bipolar) _____

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Weight Intake and History

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Patient Information:

Patient Name:_____ Goal Weight:_____

1. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

2. Previous diets you have followed (Give dates and results of weight loss):

_____

_____

_____

3. Is your spouse, fiancée, or partner overweight? ☐ Yes ☐ No

4. Do you wake up hungry at night? ☐ Yes ☐ No

5. Food allergies: _____

6. Food dislikes: _____

7. What foods do you crave: _____

8. Do you frequently skip meals? ☐ Yes ☐ No

9. Do you have any of the following conditions? (Mark X on any that apply)

- ☐ Recent Heart Attack in the last six months
- ☐ Seizure Disorder (active/currently treated)
- ☐ Arrhythmias, valvular heart disease or Atrial Fibrillation which requires Coumadin
- ☐ Active GI Bleed/Peptic ulcer disease in the past 6 month
- ☐ Severe kidney or liver disease
- ☐ Congestive Heart Failure
- ☐ Recent TIA (mini stroke) or Stroke in the past 6 months
- ☐ Glaucoma
- ☐ Drug or alcohol addiction**
- ☐ Bulimia/Anorexia other uncontrolled psychiatric disturbances
- ☐ Age under 18 or over 70
- ☐ Breast Feeding
- ☐ Type 1 diabetes or Type 2 Diabetes which requires Insulin**

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Item	Response catagories				
In the past 12 months:	*0*	*1*	*2*	*3*	*4*
1. I find myself consuming certain foods even though I am no longer hungry.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
2. I worry about cutting down on certain foods.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
3. I feel sluggish or fatigued from overeating.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
4. I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
5. I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
6. I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating.	no	yes	-	-	-
7.Eating the same amount of food does not reduce negative emotion or increase pleasurable feelings the way it used to.	no	yes	-	-	-
8.My behavior with respect to food and eating causes significant distress.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily
9. I experience significant problems in my ability to function effectively (daily routine, job/school, social activitites, family activities, health difficulties) because of food and eating.	never	once a month	2-4 times a month	2-3 times a week	4 or more times or daily

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. My signature indicates the above information is correct

Signature: _____

Reviewed by: (Medical Professional) _____

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Female Symptom MRS Questionnaire

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Which of the following symptoms apply to you at this time?

Please, mark the appropriate box:

	None	Mild	Moderate	Severe	Extremely Severe
• Hot flushes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
• Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
• Sleep problems (difficulty in falling asleep, difficulty in sleeping though, waking up early)	☐	☐	☐	☐	☐
• Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
• Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
• Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
• Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
• Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
• Bladder problems (difficulty in urinating, increased need to Urinate, bladder incontinence	☐	☐	☐	☐	☐
• Dryness of vagina (sensation of dryness or burning in the Vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
• Joint and muscular discomfort (pain the in the joints, Rheumatoid complaints)	☐	☐	☐	☐	☐

Prior or Current Hormone Use (please list all that apply): _____

Hysterectomy: ☐ Yes ☐ No If yes, ☐ Total ☐ Partial

Regular Periods: ☐ Yes ☐ No First day of last period: _____

Hx Breast or Uterine Cancer in past 5 years: ☐ Yes ☐ No

Hx Abnormal Mammogram ☐ Yes ☐ No Date of most recent exam: _____

Hx Uterine Bleeding: ☐ Yes ☐ No

Hx Abnormal Pap: ☐ Yes ☐ No Date of most recent exam: _____

Hx Bone Density: ☐ Yes ☐ No

Comments: _____

Desire to have children in the future: ☐ Yes ☐ No

Patient Name_____ ☐ Pre ☐ Post Insertion Date_____

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Patient Informed Consent for Weight Loss Program and Appetite Suppressants

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I. Procedure and Alternatives:

1. I, _____ (patient), am voluntarily enrolling in/or have enrolled in an aggressive weight management program, through Blue Sky MD. I hereby authorize Blue Sky MD and whomever they designate as assistants, to provide medical care to assist me in my weight reduction efforts, to achieve the goals of weight loss and weight maintenance. I understand that such care may include but is not limited to physical examination, laboratory screening, EKG testing, intense follow-ups, psychological therapy, instruction in behavior modification techniques, nutritional counseling, fitness counseling, vitamin supplementation, and may involve the use of appetite suppressants. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the product literature, and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I agree to disclose any past or current medical conditions or problems that may exist or would be consistent with any of the conditions or problems in the cautionary statement. I have read and I understand that the conditions and contraindications that are outlined in the cautionary statement.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

6. Patients, who are pregnant or are trying to conceive, should not be taking prescription appetite medications. Please notify our staff or doctor should you have any missed or irregular periods. Mothers who are breastfeeding should not use prescription appetite suppressants and patients with a history of alcohol and/or drug abuse should not use appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease, heart attack and stroke. Physical injury can result from such things as increased exercise and activity. GI side effects, such as constipation, diarrhea, and/or bloating, or development of gallbladder disease from rapid weight loss. These and other possible risks could, on occasion, be serious or fatal. Age may also be a factor in prescribing these medications and is at the discretion of the examining and treating physician. Phentermine has not been studied in patients older than 65 or younger than 18, therefore we cannot guarantee the safety or effectiveness of the medication in these age groups.

Some patients may not be good candidates for prescription appetite suppressant use due to various medical reasons.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet, and many other diseases. Obesity and overweight also reduces my overall life expectancy. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am. I recognize these current risks to my health as unacceptable and wish to aggressively treat my weight by enrolling in this program.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

I further understand that upon withdrawal from this program, I will not be entitled to a refund of any previously paid monies.

WARNING:

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

Date: _____ Time: _____ Witness: _____

Printed Name: _____ Signature: _____

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HIPAA

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I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I, _____, understand that as part of my health care, Blue Sky MD originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Patient's Signature (authorized representative signing for the patient):

Signature: _____ Date: _____

By signing this document, I confirm that I fully understand and accept the terms of this consent.

FOR OFFICE USE ONLY:

Consent received by: _____ Date: _____

I further understand that Blue Sky MD reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the physicians at Blue Sky MD change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree, email).
I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

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