HOUSTON surgical specialists

Robert G. Marvin, M.D.
4120 Southwest Frwy Ste. 230
Houston, Texas 77027
Phone: 713-993-7124 Fax: 713-963-0476

# PATIENT INFORMATION

**The information provided in this form is vitally important in the planning of your surgical care. Omission of complete and accurate information to the physician could result in the delay or cancellation of your surgery as well as jeopardize the ability of the physician to provide the best possible care.**

NAME: _____ DOB: ____/____/_____ AGE: _____
FIRST MIDDLE LAST
SS#: _____/___/_____ MALE/FEMALE RACE: _____ MARITAL STATUS: S M W D

ADDRESS: _____
STREET APT# CITY STATE ZIP
HOME PHONE: _____WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____
OCCUPATION: _____ EMPLOYER: _____
ADDRESS: _____
STREET CITY STATE ZIP

**PRIMARY INSURANCE INFORMATION:** Please include the front and back copy of your insurance card(s).

INSURANCE PROVIDER: _____PROVIDER PHONE #: _____
MEMBER ID #: _____ GROUP#: _____

**POLICY HOLDER'S INFORMATION (If different than pt.):**

NAME: _____ DOB: _____/_____/_____ SS#: _____/____/_____
EMPLOYER: _____ PHONE: (____) _____-_____ ADDRESS: _____

**SECONDARY INSURANCE INFORMATION:**

INSURANCE PROVIDER: _____PROVIDER PHONE #: (___) ____-_____
MEMBER ID #:_____GROUP#: _____
**POLICY HOLDER'S INFORMATION:** NAME: _____
DOB: ____/____/_____ SS#_____/_____/_____
EMPLOYER: _____PHONE: (___) ____-_____ ADDRESS: _____

**ARE YOU RECEIVING DISABILITY BENEFITS?** ☐ **No** ☐ **Yes** IF YES, LIST REASON(S):

_____

Print Patient Name _____

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**EMERGENCY CONTACT:** _____ HOME PHONE #: (____) _____-_____

MOBILE #: (_____) _____-_____ RELATIONSHIP: _____

**TRAVEL COMPANION OR TRANSPORT SERVICE FOR OUT-OF-TOWN PATIENTS ONLY**

NAME: _____ PHONE #: (____) _____-_____

**PRIMARY CARE PHYSICIAN:** _____ PHONE #: (____) ____-_____

ADDRESS: _____

STREET CITY STATE ZIP

**HOW DID YOU HEAR ABOUT DR. MARVIN?**

☐ Web Search _____ ☐ Social Media _____ ☐ Friend/Family _____

☐ MD Referral (name) _____ Phone # _____

☐ A patient of Dr. Marvin (name) _____

**WHAT IS THE PROCEDURE OF INTEREST?**

**____ Endoscopic Sleeve Gastroplasty** **____ Gastric Bypass (Roux-en-y)**

**____ Dual Gastric Balloons** **____ Laparoscopic Sleeve Gastrectomy**

**____ Gastric Lap-Band** **____ Unsure**

_____ _____

SIGNATURE DATE

_____ _____

PARENT SIGNATURE (if patient under 18 years of age) DATE

Print Patient Name _____

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# COMPLETE MEDICAL HISTORY

**What is your current weight? _____LBS** **What is your current height? _____FT_____IN**

**Have you had previous weight loss surgery?** ☐ No ☐ Yes

If Yes, Please provide following information.

Name of Surgeon _____ Surgery date _____ Procedure performed _____

## List any medical problems you have for which you have seen a doctor or been hospitalized.

| ILLNESS | DATE | TREATMENT | OUTCOME |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you been diagnosed or treated for high blood pressure? ☐ No ☐ Yes
Have you been diagnosed or treated for diabetes? ☐ No ☐ Yes
Do you have high blood cholesterol? ☐ No ☐ Yes
Do you have high blood fats or triglycerides? ☐ No ☐ Yes
Have you ever had a Heart Attack? ☐ No ☐ Yes
Have you had an Irregular Heartbeat (arrhythmia)? ☐ No ☐ Yes
Have you had stents placed in your heart arteries? ☐ No ☐ Yes
Have you ever been diagnosed with asthma? ☐ No ☐ Yes
Have you been diagnosed or treated for Sleep Apnea? ☐ No ☐ Yes
Do you sleep with a CPAP or BiPAP machine? ☐ No ☐ Yes
Have you been diagnosed or treated for heartburn or gastro esophageal reflux (GERD)? ☐ No ☐ Yes
Have you ever had stomach ulcers? ☐ No ☐ Yes
Have you ever had blood clots in your leg veins? ☐ No ☐ Yes
Have you ever had a blood clot to the lung (pulmonary embolus or PE) ☐ No ☐ Yes
Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS)? ☐ No ☐ Yes
Have you had problems with infertility? ☐ No ☐ Yes
Do you have irregular menstruation? ☐ No ☐ Yes
Have you been treated for Arthritis or Joint Pain? ☐ No ☐ Yes
Have you been treated for Back Pain or Sciatica? ☐ No ☐ Yes
Have you ever been diagnosed or treated for Gout? ☐ No ☐ Yes
Are you ever incontinent of urine when coughing or straining? ☐ No ☐ Yes
Have you ever been anemic? ☐ No ☐ Yes
Have you ever had iron deficiency or taken iron? ☐ No ☐ Yes
Have you ever been diagnosed with Hypothyroidism? ☐ No ☐ Yes
Have you ever had thyroid surgery? ☐ No ☐ Yes
Do you take thyroid replacement medication? ☐ No ☐ Yes

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**Have any of your close relatives been treated for the following:**

| | |
|---|---|
| High blood pressure? | ☐ No ☐ Yes |
| High Cholesterol? | ☐ No ☐ Yes |
| Diabetes? | ☐ No ☐ Yes |
| Heart Attack or Heart Disease? | ☐ No ☐ Yes |
| Stroke? | ☐ No ☐ Yes |

## List all surgeries and specify if done open or laparoscopic.

| SURGERY | DATE | REASON | OPEN OR LAP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| Have you had your gallbladder removed? | ☐ No ☐ Yes |
| Have you had a hysterectomy? | ☐ No ☐ Yes |
| Have you had a tubal ligation or had your "tubes tied"? | ☐ No ☐ Yes |
| Have you had a hiatal hernia repair or Nissen Fundoplication? | ☐ No ☐ Yes |
| Have you had any operation on your stomach? | ☐ No ☐ Yes |
| Have you had a repair of an abdominal wall hernia? | ☐ No ☐ Yes |

## List all current medications, including prescriptions, vitamins, over-the-counter, and intermittently used drugs. *PLEASE PRINT.*

| NAME | STRENGTH | FREQUENCY | PURPOSE | STARTED | DAILY? | AS NEEDED |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
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| | |
|---|---|
| Do you take aspirin? | ☐ No ☐ Yes |
| Do you take Plavix (Clopidogrel)? | ☐ No ☐ Yes |
| Do you take Coumadin or Warfarin? | ☐ No ☐ Yes |
| Do you take Plaquinel or Methotrexate? | ☐ No ☐ Yes |
| Do you take any type of platelet inhibitor (i.e. effient or persantine)? | ☐ No ☐ Yes |
| Do you take any oral or injectable blood thinner? | ☐ No ☐ Yes |
| Do you take Prednisone or Dexamethasone? | ☐ No ☐ Yes |

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**List any allergies to medication and explain reactions you experienced.**

_____

_____

| | |
|---|---|
| Do you get chest pain when exercising? | ☐ No ☐ Yes |
| Do you get short of breath at rest? | ☐ No ☐ Yes |
| Do you experience irregular or excessively strong heartbeats? | ☐ No ☐ Yes |
| Do you sleep lying flat? | ☐ No ☐ Yes |
| Do you wake up at night short of breath? | ☐ No ☐ Yes |
| Have you had any blackouts? | ☐ No ☐ Yes |
| Do you get swollen ankles? | ☐ No ☐ Yes |
| Have you had easy or excessive bleeding from surgery or minor injuries? | ☐ No ☐ Yes |
| Have you had easy bruising? | ☐ No ☐ Yes |
| Do you have heavy periods? | ☐ No ☐ Yes |
| Are you still having periods? | ☐ No ☐ Yes |

| | |
|---|---|
| Do you drink alcohol? | ☐ No ☐ Yes |
| How much alcohol do you drink a week? | _____ |
| Do you use recreational drugs? | ☐ No ☐ Yes |
| Have you ever smoked tobacco products? | ☐ No ☐ Yes |
| If yes, how many years? | _____ |
| How many packages of Cigarettes a day? | _____ |

| | |
|---|---|
| Have you been diagnosed or treated for depression? | ☐ No ☐ Yes |
| Have you been diagnosed or treated for Bipolar Disorder? | ☐ No ☐ Yes |
| Have you been diagnosed or treated for Schizophrenia? | ☐ No ☐ Yes |
| Have you ever received Psychiatric treatment? | ☐ No ☐ Yes |

What was the diagnosis? _____
When was your last treatment? _____
Who were you treated by? Psychiatrist, Psychologist, or Physician (circle one)
Physicians Name _____
Physicians Telephone _____
Physicians E-mail _____

| | |
|---|---|
| Does your religion prohibit you from receiving blood products? | ☐ No ☐ Yes |
| **If you answered yes, would you consent to any of the following?** | |
| Autotransfusion with your own blood (i.e. sell saver) | ☐ No ☐ Yes |
| IV infusion of Albumin | ☐ No ☐ Yes |
| Transfusion of Platelets | ☐ No ☐ Yes |
| Transfusion of Plasma | ☐ No ☐ Yes |

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## Sleep Apnea Self-Test

The quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

(20) _____ 1. I have been told that I snore or I know that I snore.
(-50) _____ 2. I definitely do not snore.
(10) _____ 3. I have been told that I stop breathing when I sleep.
(10) _____ 4. I wake up choking.
(5) _____ 5. I sweat excessively at night.
(-5) _____ 6. (If female and above is true) I have hot flashes related to my cycle.
(2) _____ 7. I am tired and sleepy during the day even after 8 hours of sleep.
(2) _____ 8. I wake up tired and unrested.
(10) _____ 9. I suddenly wake up unable to breath.
(5) _____ 10. I have fallen asleep while driving.
(5) _____ 11. I am a restless sleeper (toss and turn a lot).
(20) _____ 12. My neck circumference is more than 17 inches.
Ask office staff to measure if unknown)
(5) _____ 13. I frequently have morning headaches.

_____ Total (more than 30 points suggests that you have SLEEP APNEA.)

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# DIETARY HISTORY

PLEASE COMPLETE THIS FORM AS PRECISELY AS POSSIBLE

| **DIET PROGRAMS:** | **# Times Tried** | **Date(s) Tried** | **Time On Diet** | **# Lbs. Lost** | **# Lbs. Regained** |
|---|---|---|---|---|---|
| **Example:** | **3** | **2001/10/16** | **2-3 moth ea.** | **5-24 lbs.** | **All+** |
| M.D. SUPERVISED | | | | | |
| ☐ Medi-Fast…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Opti-Fast…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Mayo Clinic…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Physician Diet Program…… | _____ | _____ | _____ | _____ | _____ |
| Shots: ☐ B-6…… | _____ | _____ | _____ | _____ | _____ |
| ☐ B-12…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Other…… | _____ | _____ | _____ | _____ | _____ |
| Pills: ☐Lasix (diuretic)…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Xenical…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Meridia…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Other_____…… | _____ | _____ | _____ | _____ | _____ |
| NON M.D. SUPERVISED | | | | | |
| ☐ Weight Watchers…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Nutri-Systems…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Jenny Craig…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Diet Center…… | _____ | _____ | _____ | _____ | _____ |
| ☐ TOPS…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Overeaters Anonymous…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Other_____…… | _____ | _____ | _____ | _____ | _____ |
| LIQUID DIETS | | | | | |
| ☐ Slimfast…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Sweet Success…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Liquid Protein…… | _____ | _____ | _____ | _____ | _____ |
| ☐ Other_____…… | _____ | _____ | _____ | _____ | _____ |

M.D./Clinic Name_____

Print Patient Name _____

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## DIET PROGRAMS:

| | # Times Tried | Date(s) Tried | Time On Diet | # Lbs. Lost | # Lbs. Regained |
|---|---|---|---|---|---|
| MISCELLANEOUS DIETS | | | | | |
| ☐ Low Calorie Diet…….…….. | | | | | |
| ☐ Low Fat Diet…….…….. | | | | | |
| ☐ High Protein Diet…….…….. | | | | | |
| ☐ Self-Imposed Fasts…….…… | | | | | |
| ☐ Richard Simmons…….…….. | | | | | |
| ☐ Herbal Life……....…… | | | | | |
| ☐ Cambridge Diet……..…… | | | | | |
| ☐ Dr. Atkins Diet…….…..…… | | | | | |
| ☐ Other: _____..…..…… | | | | | |
| DIET PILLS (over the counter) | | | | | |
| ☐ Acutrim…….…..... | | | | | |
| ☐ Dexatrim…….…..…… | | | | | |
| ☐ Metabolife…….…..…… | | | | | |
| ☐ Xenadrine……...…….. | | | | | |
| ☐ Other: ……...…… | | | | | |
| OTHER TYPES OF WEIGHT LOSS | | | | | |
| ☐ Psychotherapy…….……..... | | | | | |
| ☐ Acupuncture…….……... | | | | | |
| ☐ Hypnosis……..……... | | | | | |
| ☐ Subliminal Tapes……..……. | | | | | |
| ☐ Other: …….……..... | | | | | |
| EXERCISE | | | | | |
| ☐ Health Club…….……. | | | | | |
| ☐ VCR Tapes……..…….... | | | | | |
| ☐ Other _____…….. | | | | | |

How long have you been overweight? _____ Age began first diet? _____
Most weight you ever lost? _____lbs. How was weight loss obtained? _____
Are you a snacker? ☐ Yes ☐ No Favorite foods _____
Do you eat a lot of sweets? ☐ Yes ☐ No How often do you eat sweets? _____
Are you currently under a physician's care for weight loss? ☐ Yes ☐ No If yes, name and address:
_____

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# AUTHORIZATION FORM
# FOR RELEASE OF PROTECTED HEALTH INFORMATION

**By signing this form, I authorize Dr. Robert G. Marvin to use and disclose the protected health information described below regarding my case for medical or financial purposes.**

**Patient Name: _____**

**Social Security: _____ D.O.B _____**

**Name (if different from patient): _____**

**Phone: _____ Work: _____**

**Address: _____ City: _____**

**State: _____ Zip Code: _____**

**The type of health information you may release subject to this authorization is as follows:**

---

**Non-Medical Individuals (Family/Friends) I authorize my Protected Health Information to are as follows:**

**Name: _____ Relationship: _____**

---

**Release my protected health information to the following person(s)/ entity:**

**Houston Surgical Specialists**
**4120 Southwest Freeway Ste. 230**
**Houston, TX 77027**
**Office: 713-993-7124**
**Fax: 713-963-0476**

**HIV / AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

**Signature: _____ Date: _____**

Print Patient Name _____

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# HOUSTON SURGICAL SPECIALIST
# INSURANCE PAYMENT FORM

**Date:** _____

**Policy Holder:** _____**D.O.B.** _____

**Employer:** _____ **Phone#** _____

**ID#:** _____**Group#** _____

**SS#:** _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

**Houston Surgical Specialist**
**3429 West Holcombe**
**Houston, TX 77025**

If my current policy prohibits direct payment to doctor, I also instruct you to make the check to me and mail it to the address above.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**.** This payment will not exceed my reasonable and customary charges to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment as stated in my policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated: _____

**X**_____ _____
**Signature of Policy/Signature of Claimant, if other than Policyholder** **Witness**

Print Patient Name _____

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# MEMBER AUTHORIZATION FORMS FOR DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

Date: _____

Member's Name: _____ Member's Address: _____

Insurance company: _____ Member's policy ID #:_____

I hereby authorize **Dr. Robert Marvin/Houston Surgical Specialists** to appeal my insurance company, _____, concerning services provided on my behalf, as my DESIGNATED REPRESENTATIVE. I hereby authorize my Insurance Company to discuss and disclose any information in connection with the processing of my appeal. Furthermore, I authorize my Insurance Company to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism, drug abuse, mental disorder and HIV status as it relates to my examination, treatment and hospital and confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

**This authorization is valid for my dates of services provided by the doctor.**

**X**_____
Signature of Member or Legal Guardian/Representative

Signature of Witness _____

Designated Representative_____

Name of Witness/Designated Representative (Please Print)

_____
Title (if on provider's staff) or Relationship to Member

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO **ROBERT MARVIN M.D- HOUSTON SURGICAL SPECIALISTS** FOR HIS/HER SERVICES._____
**Initial**

Print Patient Name _____

HOUSTON surgical specialists

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**PLEASE USE THIS FORM AS A TEMPLATE FOR YOUR INSURANCE CARD**

**PROVIDE A FRONT AND BACK COPY**

**THEY MUST BE READABLE**

Front Copy

Back Copy

Print Patient Name _____