

TEXAS CENTER

FOR BARIATRICS & ADVANCED SURGERY

Dr. A. JOSEPH CRIBBINS III, M.D.

6020 West Parker Road, Suite 430 • Plano, Texas 75093

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

GENERAL SURGERY PATIENT FORM

PATIENT INFORMATION (PLEASE ENTER FULL LEGAL NAME)		
Last:	First:	Middle:
Address:	City/State:	Zip Code:
Home Phone:	Mobile Phone:	Work Phone:
Email Address:	Employer:	Occupation:
Social Security:	Driver's License:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Widower		

PLEASE COMPLETE IF INSURANCE IS CARRIED BY SOMEONE OTHER THAN THE PATIENT		
Last Name:	First Name:	MI:
Date of Birth:	Home Phone:	Cell Phone:
Address:	City/State:	Zip Code:
SSN:	DL#:	Relationship to Patient:
Employer:	Employer Address:	
Work Phone:	Occupation:	

EMERGENCY CONTACT		
Name:	Relationship:	Phone Number:

INSURANCE INFORMATION		
Primary Insurance Company:	Phone Number:	
Policy / Certification #:	Group Account #:	
Secondary Insurance Company:	Phone Number:	
Policy / Certification #:	Group Account #:	
Pharmacy:	Phone Number:	Fax Number:

LIST ALL CURRENT PHYSICIANS	
Primary Care Physician:	Phone Number:
Physician:	Phone Number:
Physician:	Phone Number:
Physician:	Phone Number:

TELL US HOW YOU HEARD ABOUT OUR PRACTICE		
<input type="checkbox"/> Internet Search	<input type="checkbox"/> PCP/Referring Doctor (Name) _____	<input type="checkbox"/> Our Website
<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Relative or Friend (Name) _____	<input type="checkbox"/> Baylor Hospital Website
<input type="checkbox"/> Social Media	<input type="checkbox"/> Current Patient (Name) _____	<input type="checkbox"/> Texas Health Hospital Website

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

_____ _____ _____
 Signature Printed Name Date (MM/DD/Y)

A. JOSEPH CRIBBINS, M.D.

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Weight: _____ Height: _____ Date of Birth: _____ Age: _____

PHARMACY INFORMATION		
Pharmacy: _____	Phone Number: _____	Fax Number: _____
List all drug allergies: _____		

MEDICATIONS: (please list all medications you are currently taking)

NAME	DOSAGE	FREQUENCY	INDICATION	OFFICE USE

PAST SURGICAL HISTORY: (please list all surgical procedures or operations)

PROCEDURE	DATE	HOSPITAL	INDICATIONS	OFFICE USE

FAMILY HISTORY: (please indicate family members having any of the following illness with an "X")

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	SIBLINGS	CHILDREN
OBESITY								
DIABETES								
HIGH BLOOD PRESSURE								
HEART DISEASE								
CANCER								
SEIZURES								
BREATHING PROBLEMS								
KIDNEY DISEASE								
ARTHRITIS								
EARLY DEATH & CAUSE								
OTHER								

PATIENT NAME:	DOB:
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SURGICAL HISTORY: (Please <input checked="" type="checkbox"/> check all that apply and list any others)			
<input type="checkbox"/> Gallbladder Surgery	Year:	<input type="checkbox"/> Spleen Surgery	Year:
<input type="checkbox"/> Esophagus Surgery	Year:	<input type="checkbox"/> Stomach Surgery	Year:
<input type="checkbox"/> Hernia Repair	Year:	<input type="checkbox"/> Caesarian Section	Year:
<input type="checkbox"/> Abdominal Hysterectomy	Year:	<input type="checkbox"/>	Year:
<input type="checkbox"/>	Year:	<input type="checkbox"/>	Year:

SOCIAL HISTORY: (Please <input checked="" type="checkbox"/> check all that apply)		
<input type="checkbox"/> Do you currently smoke/vape?	<input type="checkbox"/> Have you ever smoked/vaped?	Year Quit:
<input type="checkbox"/> Do you use alcohol?	If Yes, how often?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely
<input type="checkbox"/> Have you ever had a problem with substance abuse?		
<input type="checkbox"/> Have you ever been treated for depression?		
<input type="checkbox"/> Are you currently in treatment? If Yes, Name of Therapist:		
<input type="checkbox"/> Have you ever been hospitalized for mental illness? If Yes, Where:		

RECENT TESTING: (Please <input checked="" type="checkbox"/> check all that apply)			
<input type="checkbox"/> Physical	Date:	<input type="checkbox"/> Upper GI	Date:
<input type="checkbox"/> Chest X-Ray	Date:	<input type="checkbox"/> EKG	Date:
<input type="checkbox"/> Echocardiogram	Date:	<input type="checkbox"/> Covid-19	Positive/Negative Date:

SYSTEM REVIEW: (Please <input checked="" type="checkbox"/> check all that apply)		
Constitutional		
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Tiredness	<input type="checkbox"/> Recent Weight Loss
<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/> Anemia		
Head and Neck		
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Loss of Vision
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Vertigo Sinus Congestion	<input type="checkbox"/> Runny Nose
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Lump in Neck	<input type="checkbox"/> Pain Swallowing	
Genitourinary		
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Leakage of Urination
<input type="checkbox"/> Pain with Urine	<input type="checkbox"/> Trouble Starting Urine	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Bladder Infection		

PATIENT NAME:	DOB:
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SYSTEM REVIEW: (Please <input checked="" type="checkbox"/> check all that apply)		
Cardiovascular		
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pain in Arm/Neck	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Pounding	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pain in Legs	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Loss of Pulses	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Abnormal Heart Beats		
Respiratory		
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Asthma	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Cough	<input type="checkbox"/> Bloody Sputum	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty Sleeping Flat
<input type="checkbox"/> Walking at Night Short of Breath		
Gastrointestinal		
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Pain with Bowel Movements	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Change in Stool Size	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Colitis
Men		
<input type="checkbox"/> Discharge from Penis	<input type="checkbox"/> Loss of Erection	
Women		
<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Abnormal Vaginal Bleeding	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Pap Exam within the last year	

SYSTEM REVIEW (cont.): (Please <input checked="" type="checkbox"/> check all that apply)		
Musculoskeletal		
<input type="checkbox"/> Pain in Joints	<input type="checkbox"/> Muscular Aches	<input type="checkbox"/> Swelling of Joints
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Pain in Hips	<input type="checkbox"/> Pain in Knees
<input type="checkbox"/> Pain in Ankles	<input type="checkbox"/> Pain in Feet	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Numbness in Feet or Legs
<input type="checkbox"/> Abnormal Lumps or Masses		
Endocrine		
<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Previous Radiation
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Adrenal Gland Tumor	<input type="checkbox"/> Previous Steroid Use
<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Goiter	
Skin/Breast		
<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Abnormal Moles	<input type="checkbox"/> Burns
<input type="checkbox"/> Rash	<input type="checkbox"/> Breast Mass	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Mammogram within Last Year	<input type="checkbox"/> MRSA	

PATIENT NAME:	DOB:
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SYSTEM REVIEW (cont.): (Please <input checked="" type="checkbox"/> check all that apply)		
Neurological		
<input type="checkbox"/> Seizures	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Fainting
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tremors
<input type="checkbox"/> Light Headedness	<input type="checkbox"/> Falling	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Stroke	<input type="checkbox"/> Loss of Consciousness	
Psychological		
<input type="checkbox"/> Depression	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Binge Eating
<input type="checkbox"/> Counseling	<input type="checkbox"/> Hospitalization (Mental Problem)	<input type="checkbox"/> Bipolar Disorder

Please list all other medical conditions, illnesses or important information not previously mentioned.

 _____ Patient Signature The above is true, correct, and complete to the best of my belief.	_____ Date (MM/DD/YY)
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Medical information has been reviewed by:

_____ Physician Signature	_____ Date (MM/DD/YY)
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A. JOSEPH CRIBBINS, M.D.

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In our efforts to comply with the **HIPPA** (Health Information Privacy Act, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please check yes or no to the following questions.

May we leave messages on a voicemail at work? Yes No

May we leave messages on voicemail at home? Yes No

May we leave messages on mobile voicemail/text? Yes No

May we leave information with a spouse or significant other? Yes No


Is there anyone that is not listed above that we can give information to? Yes No

If yes, please specify - _____

For any children above 18, still living at home, may we discuss your appointments and/or treatments with your parent(s) or guardian? Yes No


I would like to receive regular email updates and/or newsletters. Yes No

You must inform us, in writing, of any changes in your directives. This record takes effect September 1, 2003 and will be kept in your file with your acknowledgement of receipt of our Notice of Privacy Practices.

 _____ _____
Signature Printed Name Date (MM/DD/YY)

Notice of Physician Ownership

Dr. A. Joseph Cribbins III, MD has an ownership interest in Baylor Scott & White Medical Center-Frisco, Texas. Dr. A. Joseph Cribbins III, MD has an ownership interest in Texas Health Center for Diagnostics & Surgery-Plano, Texas. I understand that my physician may refer me to one of these facilities for surgery. I also understand that I may speak with my physician about his or her financial relationship with the facility, and that I may ask my physician to provide my treatment at a facility where he or she has no ownership interest.

 _____ _____
Signature Printed Name Date (MM/DD/YY)

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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 office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of this notice. This Notice of Privacy Practices is effective as of April 14, 2003.



Signature

Printed Name

Date (MM/DD/YY)

A. JOSEPH CRIBBINS, M.D.

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We would like to thank you for making an appointment with our office. It is important that you understand the procedures of our office regarding Surgery.

- You are responsible for getting referrals and keeping them updated with our office. All records request from other physician’s records, and any other records required for the approval process.
- You must pay any copays, deductibles or deposits at your pre-operative appointment at our office prior to your surgery. We do not offer payment arrangements.

Please read carefully & sign acknowledgment.

- I hereby authorize A. JOSEPH CRIBBINS, M.D. to furnish medical records &/or test results including HIV status, via fax or mail, to my referring doctor, insurance companies and to the doctor to whom I am referred concerning my illness or treatment. I will not hold A. JOSEPH CRIBBINS, M.D. or its employees responsible for any misdirected records or correspondence. I authorize payment of all medical benefits to A. JOSEPH CRIBBINS, M.D.
- An assistant surgeon, PA or CRNFA (certified registered nurse first assist) may be assisting with your surgery. The assistant surgeon is out of network with all insurance companies.
- The office staff will notify you if there will be a deposit due for the assistant. If your insurance company pays the assistant surgeon's fee, the deposit will be refunded back to you. If your insurance company does not pay, we will keep the deposit and accept that as payment in full for the assistant surgeon. Refunds are given according to office policy and after all deductible, copays, co-insurance and claims have been paid. This amount is not included in out of pocket maximums.
- There is a \$15.00 fee for completing Family Medical Leave or disability papers each time they are requested.
- I hereby certify that I have provided A. JOSEPH CRIBBINS, M.D. my current Insurance, address, phone numbers, and any other pertinent information. I also understand that failing to disclose this information could result in my insurance carrier not providing benefits for this service.

TO ALL PATIENTS: If for any reason you decide to cancel your surgery, please inform us at least 48 hours in advance to avoid a \$250.00 cancellation fee.



Signature

Printed Name

Date (MM/DD/YY)

