TEXAS CENTER
FOR BARIATRICS & ADVANCED SURGERY

DR. A. JOSEPH CRIBBINS III, MD & DR. ANDREW KHALIL, DO
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: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ 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

☐ Internet Search ☐ PCP/Referring Doctor (Name) _____ ☐ Our Website
☐ Insurance Company ☐ Relative or Friend (Name) _____ ☐ Baylor Hospital Website
☐ Social Media ☐ Current Patient (Name) _____ ☐ 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

PATIENT MEDICAL HISTORY QUESTIONNAIRE

DR. A. JOSEPH CRIBBINS III, MD & DR. ANDREW KHALIL, DO
6020 West Parker Road, Suite 430 • Plano, Texas 75093

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:

SURGICAL HISTORY: (Please ☑ check all that apply and list any others)			
☐ Gallbladder Surgery	Year:	☐ Spleen Surgery	Year:
☐ Esophagus Surgery	Year:	☐ Stomach Surgery	Year:
☐ Hernia Repair	Year:	☐ Caesarian Section	Year:
☐ Abdominal Hysterectomy	Year:	☐	Year:
☐	Year:	☐	Year:

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

RECENT TESTING: (Please ☑ check all that apply)				
☐ Physical	Date:	☐ Upper GI		Date:
☐ Chest X-Ray	Date:	☐ EKG		Date:
☐ Echocardiogram	Date:	☐ Covid-19	Positive/Negative	Date:

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

PATIENT NAME:	DOB:

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

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

PATIENT NAME:	DOB:

SYSTEM REVIEW (cont.): (Please ☑ check all that apply)		
Neurological		
☐ Seizures	☐ Convulsions	☐ Fainting
☐ Muscle Weakness	☐ Numbness	☐ Tremors
☐ Light Headedness	☐ Falling	☐ Vertigo
☐ Stroke	☐ Loss of Consciousness	
Psychological		
☐ Depression	☐ Nervousness	☐ Anxiety
☐ Suicidal Thoughts	☐ Suicide Attempt	☐ Schizophrenia
☐ Anorexia	☐ Bulimia	☐ Binge Eating
☐ Counseling	☐ Hospitalization (Mental Problem)	☐ 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

Medical information has been reviewed by:

_____ _____

Physician Signature Date (MM/DD/YY

A. JOSEPH CRIBBINS III, MD & ANDREW KHALIL, DO
6020 West Parker Road, Suite 430 • Plano, Texas 75093

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)**

A. JOSEPH CRIBBINS, MD & ANDREW KHALIL, DO

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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 III, MD & ANDREW KHALIL, DO

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

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 III, MD /ANDREW KHALIL, DO 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 III, MD/ANDREW KHALIL, DO or its employees responsible for any misdirected records or correspondence. I authorize payment of all medical benefits to A. JOSEPH CRIBBINS III, MD/ANDREW KHALIL, DO.
- 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 III, MD/ANDREW KHALIL, DO 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)**

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Member· Authorization Form for a Designated Representative to Appeal Adverse Determination

To: _____ Date: _____

_____

_____

Member Name: _____

Member Number: _____

I hereby authorize _____ to appeal my insurance carrier's determination concerning any denials of claims or incorrect payment of claims (including delayed payment of claims), on my behalf: as my Designated Representative, and, as part of the appeal, I hereby authorize my insurance carrier in its decision letter and in connection with the processing of my appeal, 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 and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital 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 a period of one year.

☒ _____ _____ _____

Member Signature | Member Printed Name | Date (MM/DD/YY)

_____ _____ _____

Witness Signature | Printed Name | Date (MM/DD/YY)