

CENTER FOR VIDEOSCOPIC & LASER SURGERY INC.

*J. Barry McKernan, M.D., Ph.D., F.A.C.S.*

2001 PROFESSIONAL PARKWAY, SUITE 110

WOODSTOCK, GA. 30188

(770) 924-8808

Thank you for your interest in our minimally invasive **surgical weight control program**. Although we are **NOT a preferred provider for any insurance company**, we aggressively pursue surgical pre-certification, as well as file claims and appeals with insurance companies. Many patients utilize their out-of-network benefits and any credit balance will be reimbursed to the patient. The initial office visit/consultation fee\* of \$385.00 is payable, in full, at the time of visit. Surgical fees are due two weeks prior to surgery date. Our protocol requires a psychological evaluation and dietary consultation, which we also use for pre-certification clinical information for insurance companies. **Obesity has now been recognized as a medical disease** and physician-directed weight treatment programs are tax deductible (for more about this, please visit [www.IRS.gov](http://www.IRS.gov)).

Center for Videoscopic & Laser Surgery does not want finances to stand in the way of anyone's weight loss goals. Therefore we now offer **multiple financing options for Lap-Band® surgery** (financing available for gastric by-pass through Capital One®). Not only can financing be beneficial for those without insurance, it can be helpful if you have a large out-of-pocket expense due to unpaid deductible or co-insurance amount. Most patients prefer to finance the entire program (Office visits for surgeon and psychiatrist, Lap-Band® surgery, facility fee, and anesthesia). You may speak with Danette Beringer for more information regarding financing.

**Please fill out the enclosed "Dietary History" and fax to (770) 924-8266 or mail to 2001 Professional Parkway, Suite 110 Woodstock, GA 30188, or you can also e-mail it to [jbmckernan@videoscopicgsurgery.com](mailto:jbmckernan@videoscopicgsurgery.com).** Should you need to reschedule or have additional questions, please call us at: (770) 924-8808.

We look forward to helping you achieve your weight loss goals.

Best Regards,

**J. Barry McKernan, M.D., Ph.D., F.A.C.S., A.S.G.S., Surgeon**

**\*Initial visit and consultation fee is \$ 385.00 and due at the time of visit. This fee includes a visit with Dr. McKernan and Dietary Consultation with Registered Dietician. Dietary Consultation will be scheduled at a different time than initial office visit.**

## Obesity Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Co-Morbidities (check ✓ all that apply):

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Ankle/foot pain    | <input type="checkbox"/> anxiety              | <input type="checkbox"/> asthma               | <input type="checkbox"/> back pain      |
| <input type="checkbox"/> cardiac disease*   | <input type="checkbox"/> COPD                 | <input type="checkbox"/> Depression           | <input type="checkbox"/> Diabetes**     |
| <input type="checkbox"/> DVT                | <input type="checkbox"/> gallbladder          | <input type="checkbox"/> GERD                 | <input type="checkbox"/> hemorrhoids    |
| <input type="checkbox"/> Hiatal hernia      | <input type="checkbox"/> hip pain             | <input type="checkbox"/> high cholesterol     | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Immobility           | <input type="checkbox"/> Joint pain           | <input type="checkbox"/> Knee pain      |
| <input type="checkbox"/> Liver disease      | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Skin chafing         | <input type="checkbox"/> Sleep apnea    |
| <input type="checkbox"/> Snoring            | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Venous insufficiency | <input type="checkbox"/> Ventral hernia |

\*Cardiac disease: List cardiologist's name: \_\_\_\_\_

\*\*Diabetes: List doctor's name: \_\_\_\_\_

Check ✓ your diabetic description(s):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Type II            | <input type="checkbox"/> Insulin Dependant          | <input type="checkbox"/> Controlled by medication       |
| <input type="checkbox"/> Controlled by diet | <input type="checkbox"/> uncontrolled/on medication | <input type="checkbox"/> uncontrolled/not on medication |

### Personal Weight Loss History

How many years have you had a weight **PROBLEM**? \_\_\_\_\_

What was your single **GREATEST** weight loss? \_\_\_\_\_

How long did you sustain this weight loss? \_\_\_\_\_

How did you lose this weight? (Prescription drugs, weight loss program, etc.) \_\_\_\_\_

Approximately, what is your **LOWEST** weight in the last 5 years? \_\_\_\_\_

Approximately, what is your **HIGHEST** weight in the last 5 years? \_\_\_\_\_

What is your **DESIRED** weight? \_\_\_\_\_

How long have you been at your **CURRENT** weight? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Weight Loss Program History** (check ✓ all that apply)

- |   |  |  |
|---|--|--|
| <b>MD Supervised Diets</b><br><input type="checkbox"/> Medi-Fast<br><input type="checkbox"/> Opti-Fast<br><input type="checkbox"/> Lindora<br><input type="checkbox"/> H.C.G. injections<br><input type="checkbox"/> B-6 injections<br><input type="checkbox"/> B-12 injections   | <b>Prescription Drugs</b><br><input type="checkbox"/> Fen-Phen<br><input type="checkbox"/> Redux<br><input type="checkbox"/> Xenical<br><input type="checkbox"/> Ampetamines<br><input type="checkbox"/> Meridia<br><input type="checkbox"/> Phentermine<br><input type="checkbox"/> Tenuate<br><input type="checkbox"/> Other   | <b>Other Misc. Diets</b><br><input type="checkbox"/> Acupuncture<br><input type="checkbox"/> Ayds<br><input type="checkbox"/> Cambridge<br><input type="checkbox"/> Diabetic Diet<br><input type="checkbox"/> Fasting<br><input type="checkbox"/> Herbal life<br><input type="checkbox"/> High protein diet<br><input type="checkbox"/> Hypnosis<br><input type="checkbox"/> liquid protein<br><input type="checkbox"/> low calorie diet<br><input type="checkbox"/> low fat diet<br><input type="checkbox"/> Magazine diets<br><input type="checkbox"/> Metral cal<br><input type="checkbox"/> Pritikin<br><input type="checkbox"/> psychotherapy<br><input type="checkbox"/> Scarsdale<br><input type="checkbox"/> Sego<br><input type="checkbox"/> Slimfast<br><input type="checkbox"/> subliminal tapes<br><input type="checkbox"/> Susan Powter<br><input type="checkbox"/> Sweet Success<br><input type="checkbox"/> self-induced vomiting<br><input type="checkbox"/> Other |
| <b>Exercise Programs</b><br><input type="checkbox"/> Jazzercise<br><input type="checkbox"/> Richard Simmons<br><input type="checkbox"/> Fitness center<br><input type="checkbox"/> Personal trainer<br><input type="checkbox"/> Other   | <b>OTC Drugs</b><br><input type="checkbox"/> Dexatrim<br><input type="checkbox"/> Ephedra<br><input type="checkbox"/> Herbal medications<br><input type="checkbox"/> Herbal supplements<br><input type="checkbox"/> Accutrim<br><input type="checkbox"/> Diurex<br><input type="checkbox"/> Laxative<br><input type="checkbox"/> Diuretics<br><input type="checkbox"/> Other |  |
| <b>Proprietary Weight Loss Program</b><br><input type="checkbox"/> Weight Watcher's<br><input type="checkbox"/> Nutri-system<br><input type="checkbox"/> Jenny Craig<br><input type="checkbox"/> The Diet Center<br><input type="checkbox"/> TOPS<br><input type="checkbox"/> Overeater's Anonymous<br><input type="checkbox"/> South Beach Diet<br><input type="checkbox"/> Atkin's Diet<br><input type="checkbox"/> Other |  |  |

➡ **What is your MOTIVATION for overeating?** (check ✓ all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Stress/emotional triggers  | <input type="checkbox"/> Social/entertainment association | <input type="checkbox"/> Medication induced association |
| <input type="checkbox"/> Rebound/reward for dieting | <input type="checkbox"/> Boredom/habit                    | <input type="checkbox"/> Other                          |

➡ **What are your FOOD PREFERENCES?** (check ✓ all that apply)

- |                                     |                                    |                                       |                                      |   |
|-------------------------------------|------------------------------------|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Candy      | <input type="checkbox"/> Cookies   | <input type="checkbox"/> Pizza        | <input type="checkbox"/> Vegetables  | <input type="checkbox"/> Dairy products |
| <input type="checkbox"/> Chocolate  | <input type="checkbox"/> Nuts      | <input type="checkbox"/> Chips/snacks | <input type="checkbox"/> Fruit       | <input type="checkbox"/> Poultry        |
| <input type="checkbox"/> Cakes/pies | <input type="checkbox"/> Fast food | <input type="checkbox"/> Seafood      | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Steak/red meat |

➡ **What are your DIETARY HABITS?** (check ✓ all that apply)

- |  |  |   |   |                                      |                                       |
|--|--|---|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Binge eating  | <input type="checkbox"/> Large portions  | <input type="checkbox"/> High fat items   | <input type="checkbox"/> Excessive sweets | <input type="checkbox"/> Fast food   | <input type="checkbox"/> Speed eating |
| <input type="checkbox"/> Skipped meals | <input type="checkbox"/> Frequent snacks | <input type="checkbox"/> Non-contributory | <input type="checkbox"/> Sweets (bedtime) | <input type="checkbox"/> Sweets (am) | <input type="checkbox"/> Sodas        |

I attest that the information that I have provided is correct, to the best of my knowledge, and I will notify the office of Dr. J. Barry McKernan of any changes in my health status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

2<sup>nd</sup> Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

All medical information contained in your chart may be used for treatment, payment and filing insurance. All other releases of your medical information will require a separate signed release at the time information is requested. Please read the following questions and initial your answer:

Whom may we speak with regarding your condition (Please include referring Physician)? \_\_\_\_\_

How may we contact you regarding your condition (please INITIAL all that apply):

<u>INITIAL</u>	<u>INITIAL</u>	<u>INITIAL</u>
_____ Home phone	_____ Home Voice Message	_____ Pager
_____ Work phone	_____ Work Voice Message	_____ Fax
_____ Cell Phone	_____ Cell phone Voice Message	_____ Email

Regarding my account, I plan to use:

Available Insurance Benefits & pay balance

Self-pay option

Financing option

**PRIMARY INSURANCE**

INSURANCE CO: \_\_\_\_\_  
 ID NUMBER: \_\_\_\_\_  
 GROUP NUMBER: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 Insured's Social Security #: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_  
 Insured's BIRTHDATE: \_\_\_\_\_  
 Insurance Co. ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_  
 Insurance PHONE NO: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE CO: \_\_\_\_\_  
 ID NUMBER: \_\_\_\_\_  
 GROUP NUMBER: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 Insured's Social Security #: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_  
 Insured's BIRTHDATE: \_\_\_\_\_  
 Insurance Co. ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_  
 Insurance PHONE NO: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT. PLEASE READ AND SIGN.**

I confirm that the above information is correct and will notify the Center for Videoscopic & Laser Surgery, Inc. if changes are needed. I hereby authorize J. Barry McKernan, M.D. to furnish information to insurance carrier(s) concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that Dr. McKernan is **no longer a preferred provider for ANY insurance policies** and I must utilize my out-of-network benefits. I understand that I am responsible for any amount not covered by insurance. Should my account become delinquent and/or turned over to a collection agency, I will be responsible for the collection late fee of \$25.00 and 1.5% interest fee per month added to my account balance.

**SIGNATURE:** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

WHAT IS THE REASON FOR YOUR VISIT TODAY?

- Obesity
- Hiatal Hernia
- Reflux
- Barrett's esophagus
- Abdominal pain
- Gallstones
- Inguinal Hernia
- Hernia, other
- Please list additional reasons:

\_\_\_\_\_

LIST PRIOR SURGERIES:

PROCEDURE NAME	DATE	OTHER INFORMATION

USE BACK TO LIST ADDITIONAL SURGERIES

MEDICATIONS (CURRENT)

MEDICATION NAME	DATE STARTED	DOSAGE INSTRUCTIONS	REASON FOR TAKING

USE BACK TO LIST ADDITIONAL MEDICATIONS

Please name previous medications & duration taken for your problem \_\_\_\_\_

ALLERGY LIST:

MEDICATION ALLERGIES	ENVIRONMENTAL ALLERGIES	FOOD ALLERGIES

USE BACK TO LIST ADDITIONAL ALLERGIES

SOCIAL HISTORY:

	YES	NO	HOW MUCH/WHAT TYPE?
DO YOU USE TOBACCO OR SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU DRINK ALCOHOL?	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU DRINK CAFFEINE	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU EXERCISE?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HAVE YOU BEEN EXPOSED TO THE FOLLOWING:</b>			<b>LIST ADDITIONAL INFORMATION</b>
HIV?	<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS?	<input type="checkbox"/>	<input type="checkbox"/>	
STD'S?	<input type="checkbox"/>	<input type="checkbox"/>	
TUBERCULOSIS?	<input type="checkbox"/>	<input type="checkbox"/>	
TRAVEL RELATED ILLNESSES?	<input type="checkbox"/>	<input type="checkbox"/>	
HAZARDOUS MATERIALS?	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT NAME: \_\_\_\_\_

FAMILY MEDICAL HISTORY

DISEASE NAME	RELATIVE	NOTES

USE BACK TO LIST ADDITIONAL FAMILY HISTORY INFORMATION

Please check any conditions for PAST and/or PRESENT Symptoms and INITIAL each section:

EYES

Patient Initials \_\_\_\_\_

- Changes in vision
- Double vision
- Eye discomfort
- Blurred Vision
- Peripheral vision changes
- Eye pain
- Impaired vision
- Discharge from eye
- Please list additional symptoms: \_\_\_\_\_

HEAD, EAR, NOSE & THROAT

Patient Initials \_\_\_\_\_

- Sore throat
- Post nasal drip
- Vertigo
- Bleeding gums
- Neck stiffness
- Breath odor
- Hearing loss
- Nasal congestion
- Sinus pain
- Lightheadedness
- Dental problems
- Neck pain
- Thyroid mass
- Ringing in ear(s)
- Nasal discharge
- Headaches
- Nose bleeding
- Dentures
- Neck tenderness
- Recent head injury
- Oral lesions
- Please list additional symptoms: \_\_\_\_\_

BREASTS

Patient Initials \_\_\_\_\_

- Lumps
- Nipple discharge
- Tenderness
- Swelling
- Please list additional symptoms: \_\_\_\_\_

CARDIOVASCULAR

Patient Initials \_\_\_\_\_

- Chest pain
- Rapid heart rate
- Syncope (*brief loss of consciousness due to lack of oxygen*)
- Cyanosis (*bluish discoloration*)
- Claudication (*leg cramps*)
- Varicose veins
- Cardiac murmurs
- Dyspnea on exertion (*shortness of breath*)
- Paroxysmal nocturnal dyspnea (*respiratory distress worsens at night*)
- Varicosities
- Lightheadedness
- Please list additional symptoms: \_\_\_\_\_
- Irregular heart beats
- Orthopnea (*must be in certain position to breathe*)
- Lower extremity edema
- Venous cords (*vein condition*)
- Orthostatic symptoms (*worsens by standing erect*)

RESPIRATORY

Patient Initials \_\_\_\_\_

- Shortness of breath
- Abnormal sputum production
- Sleep apnea
- Asbestos exposure
- Wheezing
- Hoarseness
- Anesthetic problems
- Please list additional symptoms: \_\_\_\_\_
- Cough
- Hemoptysis (*coughing up blood from the respiratory tract*)
- TB exposure

PATIENT NAME: \_\_\_\_\_

GASTROINTESTINAL

Patient Initials \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Loss of appetite   | <input type="checkbox"/> Early satiety ( <i>premature feeling of being full</i> )      | <input type="checkbox"/> Heartburn  |
| <input type="checkbox"/> Dysphagia ( <i>difficulty swallowing</i> )               | <input type="checkbox"/> Odynophagia ( <i>pain while swallowing</i> )                  | <input type="checkbox"/> Hematemesis ( <i>vomiting blood</i> )                    |
| <input type="checkbox"/> Nausea   | <input type="checkbox"/> Vomiting  | <input type="checkbox"/> Excessive belching                                       |
| <input type="checkbox"/> Bloating   | <input type="checkbox"/> Change in abdominal girth                                     | <input type="checkbox"/> Diarrhea   |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Obstipation ( <i>severe constipation due to obstruction</i> ) | <input type="checkbox"/> Tenesmus ( <i>pain w/ urination or bowel movements</i> ) |
| <input type="checkbox"/> Abdominal pain   | <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Blood in stools  |
| <input type="checkbox"/> Hematochezia ( <i>red blood passing through rectum</i> ) | <input type="checkbox"/> Melena ( <i>black blood in stools or vomit</i> )              | <input type="checkbox"/> Hemorrhoids  |
| <input type="checkbox"/> Fatty stools   | <input type="checkbox"/> Mucous in stool   | <input type="checkbox"/> Narrow stools  |
| <input type="checkbox"/> Excessive flatulence ( <i>gastrointestinal gas</i> )     | <input type="checkbox"/> Please list additional symptoms: _____                        |   |

GENITOURINARY

Patient Initials \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Urgency  | <input type="checkbox"/> Frequency                           | <input type="checkbox"/> Dysuria ( <i>painful urination</i> )    |
| <input type="checkbox"/> Nocturia ( <i>excessive urination at night</i> )               | <input type="checkbox"/> Hematuria ( <i>blood in urine</i> ) | <input type="checkbox"/> Pyuria ( <i>pus in urine</i> )          |
| <input type="checkbox"/> Oliguria ( <i>diminished capacity to form and pass urine</i> ) | <input type="checkbox"/> Change in urine color               | <input type="checkbox"/> Pneumaturia ( <i>gas/air in urine</i> ) |

**WOMEN ONLY:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Decreased libido                             | <input type="checkbox"/> Dyspareunia ( <i>painful intercourse</i> )                  | <input type="checkbox"/> Genital sores                           |
| <input type="checkbox"/> Irregular menses                             | <input type="checkbox"/> Hot flashes   | <input type="checkbox"/> Dysmenorrhea ( <i>painful periods</i> ) |
| <input type="checkbox"/> Menorrhagia ( <i>heavy or long periods</i> ) | <input type="checkbox"/> Metrorrhagia ( <i>uterine bleeding other than periods</i> ) | <input type="checkbox"/> Vaginal discharge                       |
| <input type="checkbox"/> Possible pregnancy                           | <input type="checkbox"/> Amenorrhea ( <i>no periods</i> )                            |  |
| <input type="checkbox"/> # of pregnancies _____                       | <input type="checkbox"/> # of births _____   | # Spontaneous abortion or induced _____                          |
|   | C-section or vaginal _____   | List complications (if any) _____                                |

**MEN ONLY:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Decreased libido                        | <input type="checkbox"/> Scrotal mass                           | <input type="checkbox"/> Penile discharge |
| <input type="checkbox"/> Hematospermia ( <i>blood in semen</i> ) | <input type="checkbox"/> Penile lesions                         | <input type="checkbox"/> Impotence        |
| <input type="checkbox"/> Scrotal pain                            | <input type="checkbox"/> Please list additional symptoms: _____ |   |

INTEGUMENT

Patient Initials \_\_\_\_\_

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Skin rash                            | <input type="checkbox"/> Itching                                | <input type="checkbox"/> Skin lesions                               |
| <input type="checkbox"/> Changes to existing lesions or moles | <input type="checkbox"/> Pigmentation changes                   | <input type="checkbox"/> Skin dryness                               |
| <input type="checkbox"/> Hair growth change                   | <input type="checkbox"/> Nail changes                           | <input type="checkbox"/> Hirsutism ( <i>excessive hair growth</i> ) |
| <input type="checkbox"/> Acne                                 | <input type="checkbox"/> Please list additional symptoms: _____ |   |

NEUROLOGICAL

Patient Initials \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headaches – migraine                   | <input type="checkbox"/> Tingling or numbness     | <input type="checkbox"/> Muscular weakness   |
| <input type="checkbox"/> Incoordination                         | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Memory difficulties |
| <input type="checkbox"/> Speech difficulties                    | <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Loss of balance                        |   |  |
| <input type="checkbox"/> Please list additional symptoms: _____ |   |  |

PATIENT NAME: \_\_\_\_\_

MUSCULOSKELETAL

Patient Initials \_\_\_\_\_

- Bone pain
- Muscle pain
- Muscular weakness
- Knee pain

- Back pain
- Joint swelling
- Muscle cramps
- Back pain low

- Joint pain
- Limitation of motion
- Please list additional symptoms: \_\_\_\_\_
- \_\_\_\_\_

ENDOCRINE

Patient Initials \_\_\_\_\_

- Polyuria (*excessive passage of urine*)
- Constipation
- Decreased libido
- Weight gain
- Hirsutism
- Additional symptoms: \_\_\_\_\_

- Polydipsia (*excessive thirst*)
- Cold intolerance
- Increased libido
- Weight loss
- Hot flashes

- Loss of hair
- Heat intolerance
- Central obesity
- Acne

PSYCHIATRIC

Patient Initials \_\_\_\_\_

- Anxiety
- Delusions
- Compulsive behaviors
- Homicidal ideation
- Additional symptoms: \_\_\_\_\_

- Depression
- Feeling confused
- Impulsive behaviors
- Excessive anger

- Hallucinations
- Difficulty sleeping
- Suicidal ideation

HEME-LYMPH

Patient Initials \_\_\_\_\_

- Easy bleeding
- Purpura (*purplish brownish discolorations visible through skin*)
- Additional symptoms: \_\_\_\_\_

- Easy bruising
- Lymph node enlargement or tenderness

- Petechiae (*tiny purple or red spots on skin*)
- Pica (*abnormal craving for substances other than food*)

ALLERGIC-IMMUNOLOGIC

Patient Initials \_\_\_\_\_

- Sinus allergy symptoms
- Additional symptoms: \_\_\_\_\_

- Allergic dermatitis

- Frequent illnesses

How are you being referred to Dr. McKernan? \_\_\_\_\_

If physician referred, please list Physician's contact information:  
\_\_\_\_\_

*I attest that the information that I have provided is correct, to the best of my knowledge, and I will notify the office of Dr. J. Barry McKernan of any changes in my health status.*

Signature \_\_\_\_\_

Date \_\_\_\_\_