Patient Information

Name:	**Date of Birth:**
Address:	**Social Security #:**
City:	**Sex:** **Marital Status:**
State: **Zip:**	**Primary Language:**
Home Phone #:	**Race:**
Work Phone #:	**Ethnicity:**
Cell Phone #:	**Email address:**

Guarantor Information

Name:	**Date of Birth:**
Address:	**Social Security #:**
City:	**Employer:**
State: **Zip:**	**Employer Phone #:**
Home Phone #	**Referring Doctor:** **Phone #:**
Work Phone #	**Emergency Contact:** **Phone #:**
Cell Phone #	**Emergency Contact Relationship:**

Insurance Information

Primary Insurance:	**Secondary Insurance:**
Certificate #:	**Certificate #:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**

Referring Doctor Information

Name:	**Office Phone:**
Address:	**Office Fax:**
City:	**State:** **Zip:**

Diet History:

☐ Jenny Craig ☐ Weight Watchers ☐ NutriSystem
☐ Optifast ☐ Slim Fast ☐ MD Supervised
☐ Diet Pills ☐ Prescription Medications
☐ Other (list) _____

Age when weight became a problem: ☐ Lifelong ☐ High School ☐ After Children ☐ Later

Medical History: (check all that apply)

☐ Diabetes ☐ GERD (Severe Heartburn) ☐ Heart Attack
☐ Hypertension ☐ Asthma ☐ Heart Failure
☐ Sleep Apnea ☐ Urinary Stress Incontinence ☐ Depression
☐ Arthritis ☐ Infertility ☐ Cancer

Has your thyroid function been checked? ☐ Yes, normal ☐ Yes, abnormal ☐ No

Medications: (please include dosages)

_____

_____

_____

Medication Allergies: ☐ No Known Allergies ☐ Latex _____
☐ Penicillin ☐ Sulfa _____ ☐ Iodine _____
☐ Other: (list) _____

Additional Medical History: (explain and give dates if possible)

☐ Pneumonia _____ ☐ Kidney Problems _____
☐ Tuberculosis _____ ☐ Kidney Stones _____
☐ Blood Transfusions _____ ☐ Jaundice _____
☐ Bleeding Problems _____ ☐ Psychiatric _____
☐ Duodenal or Gastric Ulcers _____
☐ Prostate Problems (men only) _____
☐ Hepatitis _____ Hep A _____ Hep B _____ Hep C _____
☐ Gallstones _____ Removed? Yes ___ No ___

Gynecological History: (women only)

Age started menses: _____ Date of last menses: _____

Date of last pap smear: _____ Date of last mammogram: _____

# of pregnancies: _____ Number of Births_____

Do you plan to have any more children? ◯ Yes ◯ No

Surgical Procedures: (please list and date)

_____

_____

_____

Habits:

Do you smoke? ◯ Yes ◯ No Date quit: _____

Do you take street drugs? ◯ Yes ◯ No

Do you drink alcohol? ◯ Never ◯ Seldom ◯ Social ◯ Frequent

Family History: (please indicate which family member(s)

☐ Diabetes _____ ☐ Hypertension _____

☐ Heart Disease _____ ☐ Obesity_____

☐ Cancer _____ ☐ Gallstones _____

Type_____

Please describe the reasons for your interest in weight loss surgery: (optional)

_____

_____

_____

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payments of benefits to myself or to LA Surgical when they accept assignment.

Authorization To Release Medical Information: I hereby authorize LA Surgical to release any information necessary for my course of treatment.

_____

Patient Name (please print)

_____ _____

Signature (patient or parent if minor) Date