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:**

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_____

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