

THE SURGERY GROUP OF LOS ANGELES

PATIENT'S INFORMATION

Last Name	First Name	Middle Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Birthdate ____/____/____
Patient's Address					
City		State		Zip code	
Home Phone ()		Mobile Phone ()		Social Security Number	
Marital Status (Please Circle One) Single Married Divorced Separated Widowed				Email Address	
Occupation			Language Spoken		
Employer's Name			Office Phone ()		
Primary Care Physician			Office Phone ()		
Referring Physician			Office Phone ()		
PERSONAL INSURANCE INFORMATION - PRIMARY					
Subscriber's Name			Patient's Relationship to Subscriber		
Insurance			ID Number		
PERSONAL INSURANCE INFORMATION - SECONDARY					
Subscriber's Name			Patient's Relationship to Subscriber		
Insurance			ID Number		
NAME OF RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)					
Name/Relationship			Phone ()		
AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS					
I hereby authorize The Surgery Group of Los Angeles to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.					
Patient's Signature					Date

-FLIP TO PAGE 2-

THE SURGERY GROUP OF LOS ANGELES

COMPREHENSIVE PATIENT HISTORY

Patient's Name: _____

Date: _____

What is the main reason for your visit today? (Please Describe)

MEDICATION YOU ARE TAKING (Prescriptions and non-prescriptions, including aspirin, ibuprofen, Advil, Aleve, Ecotrin, Vitamins. Please include dosage and frequency.)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGIES TO FOOD/MEDICATION (INCLUDING TYPE OF REACTION)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

MEDICAL HISTORY (Please indicate if you have or have had any of the following by encircling Yes or No, followed by a brief explanation, including dates.)

- | | | | |
|-------------------------------|-----|----|-------|
| Cardiac Disease (Type) | YES | NO | _____ |
| Lung Disease (Type) | YES | NO | _____ |
| Liver Disease/Hepatitis | YES | NO | _____ |
| Kidney Disease | YES | NO | _____ |
| Diabetes | YES | NO | _____ |
| Cancer | YES | NO | _____ |
| Seizure Disorders | YES | NO | _____ |
| High Blood Pressure | YES | NO | _____ |
| Bleeding Disorder/Tendency | YES | NO | _____ |
| Orthopedic Prosthesis/Implant | YES | NO | _____ |
| Thyroid Disease | YES | NO | _____ |
| Gastrointestinal Disorder | YES | NO | _____ |
| Other Conditions (Specify) | YES | NO | _____ |

(Women) Number of Pregnancies: _____ Vaginal Deliveries: _____ C-sections: _____

SURGICAL HISTORY (please list all operations that you have had and when they were done.)

FAMILY HISTORY (Please list any family history of cancer, Crohn's Disease or Ulcerative Colitis of first, second or third degree relatives)

