THE SURGERY GROUP OF LOS ANGELES

PATIENT'S INFORMATION

Last Name	First Name	Middle Name	Sex ☐ M ☐ 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

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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.)

Condition			
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)

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