# TROY LAMAR, MD, INC

PATIENT INFORMATION

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Social Security: |
| City | State: Zip Code: |
| Marital Status: | Sex: |
| Home Phone | Cell Phone: |
| Primary Language: | Race:<br>(Caucasian, African American, Asian, Other) |
| Email Address: | Ethnicity:<br>(Hispanic or Non-Hispanic) |
| Employer: | Occupation: |
| Referring Physician: | Referring Physician Phone: |
| Emergency Contact:<br><br>Emergency Contact Relationship: | Emergency Contact Phone: |

GUARANTOR INFORMATION

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Social Security #: |
| City: | State: Zip Code: |
| Home Phone: | Cell Phone: |
| Employer: | Occupation: |

INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| Member ID #: | Member ID #: |
| Medical Group: | Medical Group: |
| Group Number: | Group Number: |
| Subscriber Name: | Subscriber Name: |
| Subscriber Date of Birth: | Subscriber Date of Birth: |

**Authorization To Pay Benefits To Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to Troy LaMar, M.D., Inc. when they accept assignment.

**Authorization to Release Medical Information:** I hereby authorize Troy LaMar, M.D., Inc. to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

**TROY LAMAR, M.D., F.A.C.S.**

Name: _____

DOB: _____

*Advanced Laparoscopic Surgery • Bariatric Surgery • Colon and Rectal Surgery • General Surgery*

**Diet History:**

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

Age when weight became a problem

- ☐ Lifelong
- ☐ After Children
- ☐ High School
- ☐ Later

**Medical History:** (check all that apply)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Diverticulitis
- ☐ High Cholesterol
- ☐ GERD (Severe Heartburn)
- ☐ Asthma
- ☐ Urinary Stress Incontinence
- ☐ Infertility
- ☐ Pulmonary Embolism
- ☐ Other: (list) _____
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Depression
- ☐ Cancer
- ☐ Blood Clots

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

**Medications:** (please include dosages and frequency)

_____

_____

_____

**Medication Allergies/Reaction:**

- ☐ No known allergies
- ☐ Latex _____
- ☐ Penicillin _____
- ☐ Sulfa _____
- ☐ Iodine _____
- ☐ Other (list) _____

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

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

**TROY LAMAR, M.D., F.A.C.S.**

Name: _____

DOB: _____

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## Gynecological History: (women only)

Age started menses: _____ Date of last menses: _____

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

# of pregnacies: _____ # 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 Mellitus _____ ☐ Hypertension _____

☐ Heart Disease _____ ☐ Obesity _____

☐ Cancer _____ ☐ Gallstones _____

Type _____ ☐ Other _____

## Please explain your reasons for weight loss: (optional)

_____

_____

_____