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: (Caucasian, African American, Asian, Other)
Email Address:	Ethnicity: (Hispanic or Non-Hispanic)
Employer:	Occupation:
Referring Physician:	Referring Physician Phone:
Emergency Contact: 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

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

☐ Penicillin _____ ☐ Sulfa _____ ☐ Latex _____ ☐ Iodine _____

☐ Other: (list) _____

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

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

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

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

Name: _____

DOB: _____

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

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 _____

☐ Heart Disease _____

☐ Cancer _____

Type _____

☐ Hypertension _____

☐ Obesity _____

☐ Gallstones _____

☐ Other _____