

Louis Fox, M.D., P.A., F.A.C.S.

Diplomate American Board of Surgery

General and Laparoscopic Surgery

Bariatric Surgery

Today's Date _____

Patient's Name _____ Age _____ Birthdate _____

What name do you prefer to be called? _____ Social Security # _____

Address _____
Street City State Zip Code

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Email Address _____

Marital Status: Married Single Divorced Widow Other _____

Employer _____ Occupation _____

Employer's Address _____ Phone () _____

Spouse's Name _____ Occupation _____ Birthdate _____

Spouse's Employer and Address _____

Work Phone () _____ Cell Phone () _____ Social Security # _____

INSURANCE INFORMATION

Primary Policy Holder

Name _____ Date of Birth _____ Social Security # _____

Insurance Company _____ Policy # _____

Address _____ Group # _____

Secondary Insurance _____ Policy # _____

Address _____ Group # _____

IN CASE OF EMERGENCY

Name of nearest relative not living with you _____

Address _____

Phone Number () _____ Cell Phone () _____ Relationship _____

AUTHORIZATIONS AND RELEASES

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance and other health plans to: Louis Fox, M.D., P.A. **I understand that I am financially responsible for all charges whether or not paid by said insurance** and hereby authorize said assignee to release all information necessary to secure payment.

I hereby grant permission for release of all medical records, documents, and associated information to Dr. Louis Fox or his authorized agent.

Signature Print Name

Filing for insurance is a courtesy offered by this office.

PERSONAL/FAMILY/SOCIAL HISTORY

DATE _____

Do you smoke now? Yes How many packs per day? _____
 No How many years? _____

Did you ever smoke? Yes How many packs per day? _____
 No How many years? _____

When did you quit? _____

Do you drink alcohol? Yes Social Only? Yes No
 No Daily? Yes No

Do you drink coffee? Yes Cups Per Day _____
 No

What medications are you currently taking?

(include birth control pills, non-prescription drugs or herbal remedies) NONE

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

List all allergies (penicillin, sulfa, iodine, foods, etc.) and describe any reaction (rash, itching etc.) NONE

NAME	REACTION
1.	
2.	
3.	
4.	

List previous surgeries/hospitalizations with dates: NONE

- 1.) _____ Yr. _____ 4) _____ Yr. _____
- 2.) _____ Yr. _____ 5) _____ Yr. _____
- 3.) _____ Yr. _____ 6) _____ Yr. _____

How many children? _____ Ages _____
Father, age _____ Mother, age _____ Brothers, age _____ Sisters, age _____

Has anyone in your immediate family had any of the following diseases?

(Use M=Mother, F=Father, S=Sister, B=Brother, G=Grandparent)

Diabetes _____ High Blood Pressure _____ Heart Disease _____
Bleeding Disorders _____ Breast Cancer _____ Other Cancers _____
Severe Obesity _____ Blood Clotting Problems _____ Anesthesia Problems _____

FEMALE PATIENTS ONLY

Date of last menstrual period _____ Are they regular? Yes No
Periods start at age _____ Menopause at age _____
Have you ever had a mammogram? Yes No If so, date of last mammogram _____

Do you suffer from any significant condition?

- Diabetes _____
- High Blood Pressure _____
- Heart Attack/Heart Problems _____
- Heart Surgery/Angioplasty/Stent _____
- Chest Pain _____
- High Cholesterol/Triglycerides _____
- Strokes _____
- Tuberculosis _____
- Chronic Cough _____
- Asthma/Bronchitis/Emphysema _____
- Shortness of Breath or Sleep Apnea _____
- Blackouts/Fainting _____
- Convulsions _____
- Stomach Ulcers _____
- Colitis/Diverticulitis _____
- Gallbladder Disease _____
- Change in Bowel Habits _____

- Diarrhea _____
- Constipation _____
- Cancer/Type _____
- Arthritis _____
- Phlebitis/Leg Blood Clots _____
- Liver Disease/Hepatitis _____
- Blood Clotting Problems _____
- Drug or Alcohol Abuse _____
- Thyroid _____
- Bladder or Kidney Disease _____
- Prostate Problems _____
- Childhood diseases (i.e. chicken pox, measles, mumps, etc.): _____
- HIV/AIDS _____
- Problems with anesthesia or surgery _____
- _____
- _____
- _____

List any other: _____

PRIMARY CARE PHYSICIAN (PCP) INFORMATION:

Doctor's Name _____

Address _____
Street City State Zip Code

Telephone () _____

How were you referred to Dr. Fox? For example - doctor, seminar, internet, newspaper, etc. _____

WHAT PROBLEMS OR SYMPTOMS ARE YOU BEING SEEN FOR TODAY? For example - gallstones, hernia, abdominal pain, etc. Include location-left or right. (*This section must be filled out!*) _____

I verify the content and accuracy of the above information.

Date

Signature

Print Name

Louis Fox MD, PA, FACS

7777 Forest Lane C-865
Dallas, TX 75230

Phone: (972) 566-4560
Fax: (972) 566-6239

Your Physicians

<i>Referring Physician:</i>	<i>Primary Care Physician:</i>
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
<i>Cardiologist:</i>	<i>Orthopedist:</i>
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
<i>Endocrinologist:</i>	<i>Pulmonologist:</i>
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
<i>OB-Gyn:</i>	<i>Other:</i>
Name: _____	Name: _____
Address: _____ _____	Address: _____ _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Patient Name: _____