

Dr. Robert "Bud" Thompson
201 Oak Drive South Ste 108, Lake Jackson, TX 77566
Phone: 979-299-0011 Fax: 979-299-0022

Name: _____ DOB: _____
Last First M.I. MM/DD/YY
Age: _____ Height: _____ Weight: _____ Sex: M F
Street Address: _____ Apt./Unit: _____ City: _____
State: _____ Zip Code: _____
Social Security Number: _____ E-mail Address: _____
Home Phone (____)-____-____ Work Phone:(____)-____-____ Cell Phone:(____)-____
Level Of Education: _____ Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Marital Status: Single Married Divorced Widowed Number of children: _____
Spouse Information:
Name: _____ Work Phone:(____)-____
Emergency Contact:
Name: _____ Relationship: _____ Contact Phone :(____)-____

Primary Insured Information (if different from patient)
Name: _____ DOB: _____
Last First M.I. MM/DD/YY
Relationship to patient: _____
Street Address: _____ Apt./Unit: _____
City: _____ State: _____ Zip Code: _____
Social Security Number: _____
Home Phone:(____)-____-____ Work Phone:(____)-____-____ Cell Phone :(____)-____
Employer: _____ Occupation: _____
Employer Address: _____
Street Address Apt./Unit City State Zip Code
Are you using our Self Pay Option:
Do you need details on pricing and/or finance options? Y N
How did you hear about Lap Band Solutions? TV Newspaper Radio Internet
 Friend/Co Worker Name: _____ Other: _____

Responsibility Party Statement:
As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.
Patient Signature: _____ Date: _____
Insurance Information:
• Primary Insurance Company: _____ Phone Number(____)-____
Type of Plan: PPO HMO EPO POS Other
Policy/Certification Number: _____ Group Number: _____
• Secondary Insurance Company: _____ Phone Number(____)-____
Type of Plan: PPO HMO EPO POS Other
Policy/Certification Number: _____ Group Number: _____

Patient Medical and Weight Loss History

Patient Name: _____ DOB: _____

Height: _____ Weight: _____

Allergies to Medications/Other: _____

Primary Care Physician: _____ Office Phone : (_____) _____

Medications: (Please list all medications you are currently taking)

Name Of Medication	Dosage	Frequency	Indication

Past Surgical History: (Please list all surgical procedures and operations)

Procedure	Date	Location	Indications

Family History: (please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-Father	Paternal G-Mother	Paternal G-Father	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
High Cholesterol								
Stroke								
Cancer								
Seizures								
Asthma								
Arthritis								
Kidney Disease								
Early Death								

How many years have you been overweight? _____

Have you had previous weight loss surgery? NO YES (if yes please indicate below)

Weight Loss Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate which of the following diets or plans you have attempted.)

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Medifast				
Metabolife				
Nutri-System				
Optifast				
Pritikin Diet				
Slim Fast				
TOPS				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Phen-Fen				
Redux(Dexafenaflouramine)				
Xenical(Orlistat)				
Meridia				
Other				

Non Dietary-Therapies (please indicate if you have attempted any of the following weight loss treatments)

Regular Exercise Hypnosis Behavior Modification Acupuncture

Social History:

Do you use tobacco? **Yes No**

Number of packs per day: _____ Number of years smoking? _____

Do you use alcohol? **Yes No** Amount and Frequency: _____

Do you or have you ever used intravenous drugs? **Yes No**

Do you use recreational drugs? **Yes No**

If yes name of substance and date of last usage? _____

Do you have a history of drug addiction?

Do you have any tattoos? If yes, where? _____ Do you have any piercings? If yes, where? _____

Mental History:

Have you ever been hospitalized for mental illness? **Yes No**

Have you ever been treated for depression? **Yes No**

Are you currently in treatment? **Yes No**

If yes, please indicate the name of your physician or therapist _____ Date: _____

Patient Name: _____

DOB: _____

Systems Review: (please check all that apply)

Constitutional:

Fatigue/Tiredness Fever Night Sweats

Head and Neck:

Recent change in vision Ringing in ears? Vertigo Loss of Smell Difficulty Swallowing Painful Swallowing
Hoarseness

Do you wear glasses? Yes No

Contacts? Yes No

Do you wear a hearing aide? Yes No

Cardiovascular:

Chest Pain: At rest/Activity (circle one) High blood pressure Irregular heart beat Painful varicose veins Pacemaker
History of a heart attack Heart murmur Heart surgery Anemia Blood clot in leg (DVT) Rheumatic fever
High cholesterol. Year diagnosed _____ High triglycerides. Year diagnosed _____ Blood transfusion-year _____
Known exposure to HIV

Respiratory:

Asthma Emphysema Chronic Bronchitis Difficulty sleeping flat Snoring* Awakening at night*

Morning headaches* Daytime drowsiness* Observed apnea episodes Chronic Insomnia

How many flights of stairs can you climb? _____

Sleep apnea. Year diagnosed _____ CPAP /BiPAP (circle one)

Gastrointestinal:

Cirrhosis Elevated liver enzymes frequent nausea & vomiting Heartburn/reflux Chronic Abdominal Pain

Chronic diarrhea chronic constipation irritable bowel syndrome Ulcerative colitis Crohn's disease Fatty liver

Hepatitis: Which type? A B C

Genitourinary:

Frequent urination Leak urine with straining frequent bladder infections interstitial cystitis Kidney disease

Musculoskeletal:

Painful joints swelling of legs/feet Rheumatoid arthritis chronic low back pain Numbness of legs/feet

Chronic pain in: Hips Knees Feet ___limits ability to walk ___limits ability to exercise

Herniated disk: where? _____ Joint replacement Hip Knee

Hernia: type or location _____ year repaired _____

Neurological:

Seizures Narcolepsy fibromyalgia
 Muscles weakness Stroke muscular dystrophy
 Tremors Migraines multiple sclerosis

Psychological:

depression suicide attempts anorexia
 anxiety disorder Bi-polar disease bulimia
 Suicidal thoughts Schizophrenia

Patient Name: _____

DOB: _____

Endocrine:

- Hyperthyroid (high) Diabetes:
- Hypothyroid (low) ___ Insulin dependent
- Chronic steroid use ___ Oral medicine
- Cushing's disease ___ Diet controlled

Skins:

- wounds that don't heal psoriasis/eczema
- skin cancer lupus
- abnormal moles scleroderma
- chronic rash

Men:

- Loss of Erection
- Enlarged breast tissue
- Last prostate exam _____

Woman:

- | | | |
|--|---|-------------------------------|
| Sexually active: Y N | Menopause <input type="checkbox"/> | Last Pap smear: _____ |
| Infertility <input type="checkbox"/> | Polycystic ovarian disease <input type="checkbox"/> | Last mammogram: _____ |
| Hysterectomy <input type="checkbox"/> | Facial hair growth <input type="checkbox"/> | Last menstrual period: _____ |
| Ovaries removed <input type="checkbox"/> | Breast cancer <input type="checkbox"/> | Method of Birth Control _____ |

- | | | | |
|--|-----|----|---------------------|
| Have you ever had a Chest X-Ray | YES | NO | If yes, when? _____ |
| Have you ever had an EKG? | YES | NO | If yes, when? _____ |
| Have you ever had a Cardiac Stress Test? | YES | NO | If yes, when? _____ |
| Have you had any blood work in the last 12 months? | YES | NO | If yes, when? _____ |

Obesity Related Medical History?

Do you have or have you had any of the following illnesses or symptoms?

- | | | | |
|------------------------------------|-----|----|--------------------------|
| Heart Disease | YES | NO | Year of diagnosis? _____ |
| Angina | YES | NO | Year of diagnosis? _____ |
| MI (heart attack) | YES | NO | Year of diagnosis? _____ |
| Coronary bypass surgery | YES | NO | Year of diagnosis? _____ |
| Palpitations (abnormal heart beat) | YES | NO | Year of diagnosis? _____ |
| Congestive heart failure | YES | NO | Year of diagnosis? _____ |
| High blood pressure | YES | NO | Year of diagnosis? _____ |
| Elevated cholesterol | YES | NO | Year of diagnosis? _____ |
| Asthma | YES | NO | Year of diagnosis? _____ |
| Reflux heartburn | YES | NO | Year of diagnosis? _____ |
| Esophagitis | YES | NO | Year of diagnosis? _____ |
| Hiatel hernia | YES | NO | Year of diagnosis? _____ |

Shortness of breath

- How many blocks can you walk? _____
- How many flights of stairs can you walk? _____

- | | | | |
|------------------------|-----|----|--------------------------|
| Sleep Apnea | YES | NO | Year of diagnosis? _____ |
| Do you use CPAP/BiPAP? | YES | NO | |

Patient Name: _____

DOB: _____

Sleep difficulties

- Snoring
- Awakening at night
- Daytime drowsiness
- Observed apnea spells
- Morning headaches

Migraine

Frequency _____

Venous Stasis

- Leg or ankle Edema
- Leg ulceration

Deep venous thrombosis

Pulmonary embolism

Pain of Ankles

- In ankles
- In knees
- In hips
- Limits ability to walk
- Limits ability to exercise

Abdominal wall hernia

- Incisional
- Umbilical
- Number of hernia repairs _____

Low back pain/Sciatica

- Limits ability to walk
- Limits ability to exercise

Have you ever had/been:

- Blood transfusions
- Hepatitis
- Exposed to HIV/AIDS
- Abused intravenous drugs

Diabetes

- Juvenile onset
- Gestational (pregnancy)
- Adult onset
- Diet controlled
- Oral medications
- Insulin

Urinary Incontinence

- Leaking urine with cough
- Leaking urine with sneezing
- Leaking urine with straining

Past Medical History:

Please list all other medical conditions, illnesses, or other important information not previously mentioned:

PLEASE SIGN (by signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge)

Patient Signature: _____

Date: _____

Legal Guardian/Representative: _____

Date: _____

Request for Record Release

Dr. Robert "Bud" Thompson
201 Oak Drive South Suite 108
Lake Jackson, Texas 77566
Phone: 979-299-0011 Fax: 979-299-0022

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____
Date of Birth: _____

In order for us to evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include x-ray films and reports.

Thank you for expediting this request. Please fax these records to 979-299-0022 or email to: bcarder@brazosportsurgical.com

I hereby authorize the release of all necessary medical records to Dr. Thompson.

Patient's Signature: _____
(or parent if patient is a minor)

Date:

Signature of Witness: _____

Robert P. Thompson MD PA

Assignment of Benefits

I certify that the information I have given to Robert P. Thompson MD PA, PA, hereinafter ROBERT P. THOMPSON MD, is true and correct to the best of my knowledge. I promise to pay Robert P. Thompson MD PA, PA all charges and expenses for services provided to me in accordance with the current fees and charges to the extent that the fees and charges are not covered or paid by my insurance(s).

I request that payment of authorized benefits under any private or government insurance program be made on my behalf to ROBERT P. THOMPSON MD for services furnished to me by the providers of ROBERT P. THOMPSON MD. I authorize any holder of medical information about me to release to third party reimburses and its agents any information needed to determine benefits if applicable. ROBERT P. THOMPSON MD may pursue collection of these benefits in my name or in the name of ROBERT P. THOMPSON MD. I also authorize the use of a copy of this authorization in place of the original. I understand that possession of medical insurance does not relieve me of financial responsibility to ROBERT P. THOMPSON MD. I will personally be responsible for all charges for services that are not covered by my health insurance.

Date

Signature of Patient or Guardian

- It is okay to leave a Message/Voicemail on phone numbers given.
- It is **NOT** okay to leave a Message/Voicemail on phone numbers given.

It is okay to leave medical information with (spouse or family member)

Name: _____

Phone: _____

Relationship: _____

Robert P. Thompson MD, PA

Payment Policy

Thank you for choosing Robert P. Thompson MD as your healthcare provider. We are committed to providing you with quality health care. A copy of this pmt policy will be provided to you upon request.

Insurance Our office participates in several insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit, unless otherwise negotiated with your health plan. If you are insured by a plan we do business with, but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles All co-payments and deductibles must be paid at time of services being rendered. This arrangement is part of our contract with your insurance company. Please help us in upholding our agreement with your insurance company by paying your co-payment at each visit.

Non-covered services Please be advised that certain services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full prior to that service being rendered, unless otherwise negotiated.

Proof of insurance All patients must complete our patient information form before seeing the physician. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

Claims submission Our billing offices will submit your claims and assist you in any way we reasonably can to help get your claims processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Requested information not provided to your insurance company in a timely manner will be transferred to your responsibility. After 90 days of non-payment by the insurance company, the balance will be forwarded to patient responsibility.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive the maximum benefits. Information changes not provided prior to services being rendered will result in a denial of the claim and the balance will be your responsibility. Many of the contracts with the plans require us to file claims in a timely manner. Claims denied as past the filing deadline for incorrect information received will be transferred to your responsibility.

Missed Appointments Our policy is to charge **\$25.00** for missed appointments not canceled within 24 hours prior to the date of appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date