



PHILIP L. LEGGETT, M.D.

GENERAL AND LAPAROENDOSCOPIC SURGERY

Board Certified

Fellow American College of Surgeons

Fellow International College of Surgeons

Clinical Assistant Professor of Surgery, University of Texas

RELEASE OF MEDICAL INFORMATION

To: _____

I, _____, authorize you to release all
medical records for _____. The
date of birth for the patient is _____.

Please release to: Philip L. Leggett, M.D.
800 Peakwood, Suite 8B
Houston, Texas 77090
Phone: (281) 580-6797
Fax: (281) 580-6693

Signature: _____

Date: _____

Witness: _____



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PLEASE PRINT AND FILL OUT COMPLETELY

Patient's Name		Male <input type="checkbox"/>	Age	Date of Birth	
Address		Female <input type="checkbox"/>	Area Code		
City	State	Zip	Home ()		
Your Occupation		Business Phone ()			
Your Employer, Company Name		Employer's Street Address		City	State
Spouse's Name		Spouse's Social Security Number		Spouse's Occupation	
Spouse's Employer, Company Name		Employer's Street Address		City	State
In case of emergency please notify: Name		Phone		Relationship	
<p>We gladly file insurance for surgical procedures, however, payment in full is due within 45 days from date of service. You should keep in contact with the office concerning the status of your claim. Your account is your responsibility, not your insurance company's. This office accepts major credit cards or personal checks.</p>					
Your Insurance Co. Name		Street Address		City	State
Policy Holder's Name and Date of Birth		Group Number and/or Certificate Number		Insurance Company Phone Number	
Spouse's Insurance Co. Name		Street Address		City	State
Policy Holder's Name and Date of Birth		Group Number and/or Certificate Number		Insurance Company Phone Number	
Medicare #		Medicaid #			
Reason For Today's Visit. (what do you wish to discuss with Doctor?)			If Illness Date of first Symptoms		Any known Allergies:
Patient Medical History and past Surgeries					Any Drug Allergies:
Referring Physician or Doctor					

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Philip L. Leggett, M.D. for surgical and/or medical benefits.

I hereby authorize payment directly to Philip L. Leggett, M.D. to release any information acquired in the course of my examination and treatment.

Signature Insured

Patient's Signature

Date

We kindly request payment for services rendered at the time of first consultation visit.

PLEASE ANSWER THE FOLLOWING QUESTIONS

NAME:

Has anyone in your immediate family had any of the following ?
If yes, please indicate who.

YES NO

Gallstones.....	___	___
High Blood Pressure	___	___
Heart Disease	___	___
Diabetes Mellitus	___	___
Polyps of the colon	___	___
Cancer ... a) Breast	___	___
b) Colon or rectum	___	___
c) Other (Specify)	___	___

Habits

Do you currently smoke	___	___
How many years	___	___
Number of packs per day	___	___
Have you stopped smoking.....	___	___
If yes, when	___	___
Do you drink coffee	___	___
Number of cups per day	___	___
Do you drink beer, wine, or liquor	___	___
Number of drinks per day	___	___

Review of Systems

Height _____		Weight _____
Have you lost weight in the past six months	___	___
Was the weight loss intentional	___	___
Have you had a weight gain in the last six months.....	___	___
Do you have nausea or vomiting	___	___
Have you vomited blood.....	___	___
Do you have difficulty swallowing	___	___
At night, do you sleep with your head elevated	___	___
Do you wake at night with reflux or an acid taste in your throat ...	___	___
Are you bothered by abdominal pain	___	___
Are you bothered by abdominal bloating	___	___
Are you bothered by abdominal gas	___	___
Do you have heartburn	___	___
Do you have indigestion	___	___
Have you ever had hepatitis	___	___
If yes, when	___	___
Do you have any other liver problems.....	___	___
If yes, specify	___	___
Are you constipated	___	___
If yes, do you use enemas or take laxatives	___	___
Do you have diarrhea	___	___
Have you ever had black, tarry stools	___	___

Medical History Questionnaire

Have you ever had bright red blood in you stools — —
 Have you ever had colon polyps — —
 If yes, when — —
 Do you have hemorrhoids — —
 Do you have gallstones — —

Lungs & Heart

Do you have a persistent cough — —
 Do you bring up sputum — —
 Do you wheeze — —
 Do you have asthma — —
 Do you have a murmur or extra beat — —
 Do you have chest pains — —

Illness

Have you ever had diabetes mellitus — —
 If yes, do you take insulin — —
 If yes, do you take pills — —
 Do you have mitral valve prolapse — —
 Do you have hypertension — —
 Do you take medication for this — —
 Do you have heart disease — —

Breast -- Women Only

Do you have breast pain — —
 Do you have any discharge from your breast — —
 Have you had a previous breast biopsy — —
 If yes, when — —
 Are you able to feel any mass, lump ect in your breast — —

Women Only

Number of children — —
 Number of vaginal births — —
 Number of C-sections — —
 Health of children — —

EVERYONE

When have you last had any of the following tests:

TEST	DATE	PLACE	RESULT
Chest x-ray			
Abdominal Ultrasound			
Pelvic Ultrasound			
Barium Enema			
Upper GI Series			
Gallbladder x-ray			
Mammogram			
Other x-rays			



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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed and/or received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

MEDICATION LIST		
PATIENT NAME:		
Medication Name	Milligram	Dosage

****IF YOU DO NOT HAVE THIS INFORMATION AVAILABLE AT THE TIME OF YOUR OFFICE VISIT, WE ASK THAT YOU CALL US BACK WITH THE INFORMATION OR FAX IT TO OUR OFFICE. THIS INFORMATION IS MOST IMPORTANT!**

Thank You