



Patient Information

Name: _____ Birth Date: _____
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: (____) _____ Alt/Cell Phone: (____) _____

Level of Education: _____ Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Marital Status: married single divorced widowed Number of Children: _____

Primary Insured Information (if different than patient)

Name: _____ Birth Date: _____
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: (____) _____ Alt. Phone: (____) _____

Employer: _____ Occupation: _____

Employer Address: _____

Spouse Information

Name: _____ Work Phone: (____) _____

Emergency Contact

Name: _____ Relationship: _____ Contact Phone: (____) _____

Responsibility Party Statement: As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility. Signature: _____ Date: _____

Insurance Information

- Primary Insurance Company: _____ Type of Plan: PPO HMO EPO POS Other
 Policy /Certification Number: _____ Group Number: _____
 Phone Number: (____) _____
- Secondary Insurance Company: _____ Type of Plan: PPO HMO EPO POS Other
 Policy /Certification Number: _____ Group Number: _____
 Phone Number: (____) _____

Are you using our Self Pay Option: Do you need details on pricing and/or finance options?

How did you first hear about Lap Band Solutions? TV Newspaper Radio Internet

Friend/Co Worker Name: _____ Other: _____

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								

Patient Name: _____ DOB: _____

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				
Jenny Craig				
Liquid Diets				
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 (Sibutramine)				
Other Diet Medication				

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

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient Name: _____ DOB: _____

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 _____
Elevated triglycerides	YES	NO	Year of diagnosis _____
Asthma	YES	NO	Year of diagnosis _____
Reflux Heartburn	YES	NO	Year of diagnosis _____
Esophagitis	YES	NO	Year of diagnosis _____
Hiatal Hernia	YES	NO	Year of diagnosis _____

Shortness of breath	YES	NO	Year of diagnosis _____
How many blocks can you walk? _____			
How many flight of stairs can you walk? _____			

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

Sleep difficulties	YES	NO	
Snoring	YES	NO	
Awakening at night	YES	NO	
Daytime drowsiness	YES	NO	
Observed apnea spells	YES	NO	
Morning headaches	YES	NO	

Venous Stasis	YES	NO	
Leg or ankle Edema	YES	NO	
Leg ulceration	YES	NO	

Pain of Ankles	YES	NO	
In Ankles	YES	NO	
In knees	YES	NO	
In hips	YES	NO	
Limits ability to walk	YES	NO	
Limits ability to exercise	YES	NO	

Low back pain/Sciatica	YES	NO	
Limits ability to walk	YES	NO	
Limits ability to exercise	YES	NO	

Diabetes	YES	NO	Year of diagnosis_____
Juvenile onset	YES	NO	
Gestational (pregnancy)	YES	NO	
Adult onset	YES	NO	
Diet controlled	YES	NO	
Oral medications	YES	NO	
Insulin	YES	NO	
 Urinary Incontinence	 YES	 NO	 Year of diagnosis_____
Leaking urine with cough	YES	NO	
Leaking urine with sneezing	YES	NO	
Leaking urine with straining	YES	NO	
 Migraine	 YES	 NO	
Frequency _____			
 Deep Venous Thrombosis	 YES	 NO	 Year of diagnosis_____
Pulmonary embolism	YES	NO	
 Abdominal wall hernia	 YES	 NO	
Incisional			
Umbilical			
Number of hernia repairs _____			
 Have you ever had/been:			
Blood transfusions	YES	NO	
Hepatitis	YES	NO	
Exposed to HIV/AIDS	YES	NO	
Abused intravenous drugs	YES	NO	

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: _____



Authorization and Release

In connection with arranging laparoscopic gastric band surgery, Lap Band Solutions®, L.L.C. may require information from each patient's medical records.

I hereby grant Lap Band Solutions® permission to obtain such information from my medical records as they may require arranging the laparoscopic adjustable gastric banding surgery. In this regard and this regard only, authorized employees/agents of Lap Band Solutions® shall have the right to sign, as my representative, any information disclosure authorization required by the health care provider or other person maintaining my medical records, including authorizations required in order to comply with the privacy rules of the Health Insurance Portability & Accountability Act of 1996.

Lap Band Solutions® is further authorized to disclose such information to the health care provider performing the laparoscopic adjustable gastric banding surgery. In granting such authorizations, I release any and all claims, actions and demands against Lap Band Solutions®, its officers, directors, employees and agents that might arise as a result of any such disclosure.

Print Patient/Legal Guardian Name

D.O.B.

SS#

Patient/Legal Guardian Signature

Date

“Lose the Weight, and Regain Your Health”™

1.866.342.BAND

lapbandsolutions.com

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