Peachtree Surgical Specialists, Inc.
Clarence R. Hixon, M.D., F.A.C.S.

PATIENT INFORMATION

DATE:_____ Referred by: _____

Name:_____ DOB:_____ AGE: _____ SEX:_____

Address:_____

_____

City: *State:* *Zip:* *County:*

Home Phone:_____ Work Phone: _____Cell Phone:_____

SS#: _____ Marital Status: **S M D W** Spouse Name: _____

Patient Employer: _____

Occupation *Phone* *Extension*

Address: _____

City *State* *Zip*

EMERGENCY CONTACT:_____

Relationship *Phone*

E-MAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Policy Holder Name:_____ Relationship to Insured: _____

Birth Date:_____ Place of Employment: _____ Phone: _____

Address of Insurance Company:_____

Policy # / ID#: _____ Group #: _____

Benefits Phone #:_____ Precert Phone #:_____

SECONDARY INSURANCE CARRIER: _____

Policy Holder Name:_____ Relationship to Insured: _____

Birth Date:_____ Place of Employment: _____ Phone:_____

Address of Insurance Company: _____

Policy # / ID#: _____ Group #: _____

Benefits Phone #:_____ Precert Phone #: _____

INSURANCE AUTHORIZATION

I understand that this release includes all confidential information in my medical record, including information related to psychiatric care, drug and/or alcohol abuse and HIV/AIDS. I authorize medical information to be released via Mail, Fax, Electronic Data, or by Telephone as requested. I understand that this authorization shall remain in effect until revoked by me in writing. I understand that I have the right to receive a copy of this authorization. I authorize all insurance benefits for servies rendered by Peachtree Surgical Specialists, Inc. to be paid directly to Clarence R. Hixon, M.D. P.C.

Signature: _____ *Date:* _____

NAME: _____

DIET INFORMATION

HEIGHT: _____ WEIGHT: _____ BMI: _____

IDEAL WEIGHT: _____

Age that you first remember being overweight? _____

Age when you first began dieting? _____

Note: Fill out completely and include all diets over the counter. If not filled out completely this will delay your pre-certification process.

Diet Program	Year(s) on Plan	Weight Loss	Weight Gain	MD Supervised
Atkin's Diet				
Weight Watchers				
Over Eater Anon				
Tops				
Nutri System				
Opti-Med Fast				
Fen-Phen				
Dexatrim Pills				
Diet Shots by M.D.				
Redux				
Jenny Craig				
Mayo Clinic				
Beverly Hills Diet				
Protein Diets				
Gastric Balloon				
Scarsdale				
Diet Pills (OTC)				
Slim Fast				
Teeth Wiring				
Others Please List				
1.				
2.				
3.				
4.				

Patient Signature: _____ Date: _____

NAME: _____

MEDICAL HISTORY (PART 1)

Allergies: _____

Previous Surgery & Dates:

_____

_____

Medication & Dosage:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you smoke? **Yes** **No** How much? _____

Do you have a history of alcoholism? **Yes** **No**
If yes, length of sobriety _____

Do you use or have a history of illegal or recreational drug use? **Yes** **No**
If yes, length of sobriety _____

Are you, or have you ever been addicted to any pain medication? **Yes** **No**
If yes, length of sobriety _____

Weight Related Illnesses

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol or triglycerides
- ☐ Sleep Apnea
  - ☐ Do you use CPAP
- ☐ Heatburn, hiatal hernia, acid reflux
- ☐ Chocking or coughing at night
- ☐ Gallbladder disease
- ☐ Cancer
- ☐ Polycystic Overian Syndrome
- ☐ Breathing problems
- ☐ Leakage of uring with coughing or straining
- ☐ Back Pain
- ☐ Joint problems in hip, knee, ankle or foot
- ☐ Venous insufficiency or blood clots
- ☐ Thyroid disease
- ☐ Heart disease - provide medical records
- ☐ Depression or psychiatric disorder
- ☐ Liver disease
- ☐ Eating Disorder - provide medical records
- ☐ Heart Attack
- ☐ Stroke

Please check and write year if you have ever been diagnosed with any of the following health problems

- ☐ Hepatitis B _____
- ☐ Hepatitis C _____
- ☐ HIV/AIDS _____
- ☐ OB/GYN Problems _____

Other medical illnessess (please list)

_____

_____

_____

Patient Signature: _____ Date: _____

NAME: _____

MEDICAL HISTORY (PART 2)

PRIMARY CARE PHYSICIAN: _____

Address: _____

Phone #: _____ Fax #: _____

Name of Pharmacy: _____ Pharmacy Phone #: _____

Have you recently been, or are you currently being treated for depression or other mental illness? Yes No
If yes, please list physician information below

DOCTOR NAME: _____

Address: _____

Phone #: _____ Fax #: _____

Have you had psychological or psychiatric counseling for weight problems? Yes No
If yes, please list physician information below

DOCTOR NAME: _____

Address: _____

Phone #: _____ Fax #: _____

Have you ever seen a dietitian or nutritionist for your weight problems? Yes No
If yes, please list physician information below

DOCTOR NAME: _____

Address: _____

Phone #: _____ Fax #: _____

Job Status:

☐ Unemployed ☐ Full-Time Employed
☐ Disabled ☐ Part-Time Employed

If employed, job level of physical activity
☐ Sedentary(little activity) ☐ Moderately active ☐ Very active

Do you have children?
If yes, please list names and ages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

How did you find out about our practice? _____

Patient Signature: _____ Date: _____