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 ☐ Female ☐	Age	Date of Birth
Address City State Zip			Area Code Home ( ) Business Phone ( )		
Your Occupation			Social Security Number		
Your Employer, Company Name	Employer's Street Address	City	State	Zip	Phone Number
Spouse's Name	Spouse's Social Security Number		Spouse's Occupation		
Spouse's Employer, Company Name	Employer's Street Address	City	State	Zip	Phone Number
In case of emergency please notify: Name	Phone		Relationship		

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.

Your Insurance Co. Name	Street Address	City	State	Zip
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	Zip
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 ……	___	___

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Medi cal History Questionaire

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

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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