LANE SURGERY GROUP
4801 MCHUGH RD STE. C
ZACHARY,LA. 70791
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Lane Surgery Group
Care You Can Count On

Fredrick Bohanon, MD
Danny Bourgeois, MD
Francisco Sanfiel, MD

ALL PAGES MUST BE FILLED OUT COMPLETELY BEFORE YOU WILL SEE PHYSICIAN

LAST NAME_____ FIRST NAME_____ MIDDLE INTIAL_____

SOCIAL SECURITY # _____ LIVING WILL? YES _____ NO_____ DOB # _____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

MARITAL STATUS_____ HOME#_____ CELL#_____ EMAIL_____

REFERRING DOCTOR_____ PHONE _____

PRIMARY DOCTOR_____ PHONE_____

PHARMACY _____ ADDRESS_____

PHONE_____ FAX_____

EMPLOYER INFORMATION

EMPLOYER _____ FULLTIME/PART TIME_____

MAILING ADDRESS_____ CITY_____ STATE_____ZIP CODE_____

OFFICE PHONE_____ OCCUPATION_____

BILLING RESPONSIBLE PARTY INFORMATION

LAST NAME_____ FIRST NAME_____ DOB_____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

HOME #_____ __CELL #_____ SOCIAL SECURITY # _____

LIST (2) EMERGENCY CONTACTS

NAME_____ RELATIONSHIP_____

MAILING ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

PHONE_____ CELL # _____

NAME_____ RELATIONSHIP _____

MAILING ADDRESS_____ CITY_____ STATE_____ZIP CODE_____

PHONE_____ CELL PHONE_____

I understand that all services are charged to the patient, and as the patient, I am responsible for all charges not paid by my insurance. I hereby authorize Lane Surgery Group to obtain my medication history by means of electronic access which becomes part of my permanent record. I hereby indemnify the physician office and its agents from any and all responsibility relative to obtaining such information. I agree to pay all co-pays and uninsured charges at the time of service, unless arrangements have been made in advance. I authorize Lane Surgery Group to release my medical and financial information to my insurance carriers as necessary to receive payment. If I have no insurance, full payment is made it time of service.

DATE:_____ _____ _____ __ SIGNATURE_____

DRUG ALLERGIES_____

YOUR MEDICAL REASON FOR TODAY'S VISIT_____

HAVE YOU HAD ANY **IMAGING** OR **LABS** TO DO WITH TODAY VISIT? IF SO WHAT/WHERE/WHAT DOCTOR?_____

_____

LIST YOUR CURRENT MEDICAL PROBLEMS THAT YOU TAKE MEDICATION FOR_____

_____

Are you followed by a Cardiologist (HEART DOCTOR)? Yes No If so whom:_____

When was your last Colonoscopy? (MONTH,DAY,YEAR)_____ Doctor _____

LIST YOUR CURRENT MEDICATIONS: IF YOU NEED MORE ROOM USE BACK OF THE PAGE

NAME OF DRUG	DOSE/TIMES PER DAY	PESCRIBING PHYSICIAN

PAST SURGICAL HISTORY (PLEASE ALSO INDICATE ANY ABDOMINAL SURGERIES): IF YOU NEED MORE ROOM USE BACK OF THE PAGE

TYPE OF SURGERY	DATE WAS PREFORMED	FACILITY	PHYSICIAN

OBSTETRIC/GYN HISTORY (IF APPLICABLE):

OF PREGNANCIES_____ VAGINAL_____ C-SECTIONS_____ MISCARRIAGES_____

TOBACCO USE: YES/NO # OF CIGARETTES PER DAY_____ # OF YEARS_____

ALCOHOL USE: YES/NO # DAILY_____ #WEEKLY_____ TYPES OF BEVERAGES_____

FAMILY MEDICAL HISTORY (Immediate family such as Mother, Father ,Sister, Brother and your children)

FAMILY MEMBER	MEDICAL DIAGNOSIS	AGE DIAGNOSIS OCCURRED