COLON AND RECTAL SURGERY, LTD.

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610-565-3435

Welcome to our practice. If you have any questions concerning this form, please feel free to ask our staff for assistance.

Please circle one: Mr. Mrs. Ms. Miss Dr.

Name _____ Referred by _____

Address _____ City _____ Zip_____

Family Doctor's Name _____

Date of Birth _____ Social Security Number _____

Home Phone _____ Work Phone _____ Cell Phone _____

May We Leave a Message? Yes or No Where can message be left? Home Work Cell

Email Address _____

Marital Status _____ Spouse's Name _____ Spouse's Date of Birth _____

Spouse's Social Security _____ (required if spouse's insurance is used)

Your Occupation _____ Spouse's Occupation _____

Employer _____ Employer _____

Address _____ Address _____

Race: American Indian Asian African American Native Hawaiian White Other _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Refuse to Report

Preferred Language _____

In case of Emergency, Please Notify (other than spouse)

_____	_____	_____
Name	Relationship	Phone

HIPAA REQUIREMENTS

Our office is often asked by family members to share medical information about our patients. <u>In addition to your family physician and/or the referring physician</u>, please list below family members or other persons that you specifically authorize to discuss your medical information

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Date of Birth _____

PHARMACY INFORMATION

Local Pharmacy _____ Phone _____

Address _____ City _____ Zip _____

Mail Order Pharmacy _____ Phone _____

Address _____ City _____ Zip _____

Please provide your Health Insurance.

Primary Insurance _____

ID Number _____ Group Number _____

Subscriber (if other than yourself) _____ Relationship _____

Subscriber's Date of Birth _____ Subscriber's Social Security _____

Secondary Insurance _____

ID Number _____ Group Number _____

Subscriber (if other that yourself) _____ Relationship _____

Subscriber's Date of Birth _____ Subscriber's Social Security _____

Assignment and Release: I do hereby authorize the release of any information necessary to process this claim. I further authorize payment of benefits to the provider of services described above. I acknowledge that I am responsible personally for all non-covered services, in addition to my co-pay, coinsurance and/or deductible costs. I hereby give my permission for the provider to appeal any denial of any claim.
Privacy Policy: I have received a copy of the Privacy Policy of Colon & Rectal Surgery, LTD.
Identification: We require Photo ID for proper identification.
Photographs: We photograph our patients for identification purposes. I agree to a photo for my chart. Yes ____ No ____
Overdue Accounts: All overdue accounts over 90 days will be sent to a collection agency.

_____ _____
Signature Date

Authorization to Obtain Medication History

I hereby authorize **Colon and Rectal Surgery, Ltd.** to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

_____ _____
Signature Date of Authorization

Name _____ DOB_____ Date _____

To help us understand your health status, please complete the following brief questionaire.

Height_____ Weight_____ BP_____ Pulse_____

Please check off any of the following symptoms that you **currently** or **recently** have had

__ Poor appetite
__ Weight loss
__ Weight gain
__ Fatigue
__ Fever
__ Chills
__ Vision changes
__ Hearing loss
__ Sore throat
__ Sinus congestion
__ Fainting
__ Chest pain/pressure
__ Heart racing
__ Joint complaints
__ Rash

__ Rectal bleeding
__ Abdominal pain
__ Anal/rectal pain
__ Constipation
__ Diarrhea
__ Discharge/leakage
__ Vomiting
__ Nausea
__ Gas/bloating
__ Heartburn
__ Hemorrhoids that
__ Swell
__ Itch
__ Protrude
__ Bowel incontinence

__ Difficult urination
__ Painful urination
__ Blood in the urine
__ Urinary incontinence
__ Excessive bleeding
__ Anemia
__ Enlarged lymph nodes
__ Abnormal bruising
__ Depression
__ Anxiety
__ Insomnia
__ Mental status change
__ Headache
__ Trouble breathing
__ Chronic cough

In terms of your family tree, are there any persons with cancer of any type? If so, please indicate family member, and type of cancer if known. Use "P" to indicate father's side of family, "M" to indicate mother's. **No names, please.**

Relative	P/M	Cancer Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE COMPLETE OPPOSITE SIDE

Name _____ DOB_____ Date _____

Please list all your **current medications** with dosages, including over-the-counter products or provide a copy of your current medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please describe any allergies you may have to medications, contrast dye, Latex, etc.

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Smoking Status

____ Currently smoke ____Former smoker ____Never smoked

Alcohol use

____ Never drink alcohol ____Drink alcohol, ____drinks per week

Please list all previous surgeries or procedures with date (year). Include tonsillectomy, hernia repairs, gallbladder, appendix, cataracts and any surgery/procedure with implanted metal (joints, screws, plates, etc.)

Year	**Surgery/Procedure**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Thank You!