

Charlotte Colon & Rectal SURGERY ASSOCIATES, PA

Patient Registration

Date: _____

Account # _____

Referring Doctor (Name & Phone number): _____

Primary Care Doctor (Name & Phone Number): _____

Pharmacy Name & Address: _____

Last Name: _____ First Name: _____ MI: _____ Male Female

Date of Birth: _____ Age: _____ Marital Status : Married Single Divorced Widow/er Partner

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Preferred Language: English Spanish Unknown

Ethnicity: Hispanic/Latino Not Hispanic Latino Refused/Declined

Race: Black/African American Caucasian/White Multiracial Asian American Indian/Alaskan Native

Native Hawaiian/Other Pacific Islander Refused/Declined

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

I authorize the following people to have access to my medical records:

_____ (Relationship) _____ (Relationship)

(Continued on Reverse)

Payment Agreement

- I agree to assign payment directly to Charlotte Colon & Rectal Surgery Associates, P.A., for both basic and major medical benefits payable to me under the conditions of my insurance.
- I understand that filing of insurance is a service only, and it is not a guarantee of payment.
- I understand it is my responsibility to obtain the necessary approval for office or physician services if my insurance requires preauthorization or precertification for those services.
- I understand that I am financially responsible for the full amount of my bill if my insurance does not pay. I understand that some insurances do not pay for what are considered routine or screening examinations. Medicare and some insurance companies do not pay for supplies. Therefore, I understand that payment for these services and supplies is my responsibility.
- This practice accepts Medicare assignment. I request that payment of authorized Medicare benefits be made on my behalf to Doctors Walker, Morrison, Jerby or Rosen for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- I authorize this office to release any information acquired in the course of my treatment for insurance purposes, or to the referring physician, or to other physicians who are currently treating me. Additionally, I authorize release of my medical records to Charlotte Colon & Rectal Surgery Associates, P.A.
- I request that payment of authorized Medigap benefits be made on my behalf to Charlotte Colon & Rectal Surgery Associates, P.A. for any services furnished to me by the physicians in the group. I authorize any holder of medical information about me to release to Medigap insurance any information needed to determine these benefits.
- I assign my insurance benefits to Charlotte Colon & Rectal Surgery Associates and understand that this form is valid for one year unless cancelled through written notice.
- I hereby acknowledge that I have been presented with a copy of Charlotte Colon and Rectal Surgery Associates, P.A. Notice of Privacy Practices as mandated by Federal law under HIPPA regulations.

Authorization For Examination & Treatment

- I authorize the physicians of Charlotte Colon & Rectal Surgery Associates, P.A. to perform indicated diagnostic procedures such as flexible sigmoidoscopy, anoscopy, and proctoscopy as well as minor surgical procedures such as rubber band hemorrhoid therapy, injection of hemorrhoids, removal of thrombosed hemorrhoids, removal of tags, incision and drainage of abscesses, and other procedures where indicated. I understand these procedures may have risks of bleeding, infection, and pain. I understand that I may refuse any therapy offered.

Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Charlotte Colon & Rectal Surgery Associates, P.A. Notice of Privacy Practices as mandated by Federal law under HIPPA regulations.

Signature

Date

Printed Name

***** Please return this form to the receptionist before completing the medical history form. *****

Patient Medical History

Height: _____ Weight: _____

Reason for today's visit: _____

Past Medical History: Check all that apply.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD (lung disease) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Blood clots (DVT/PE) | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Heart attack (MI) | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Chronic renal failure | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chronic renal insufficiency | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> _____ |

Past Surgical History: When was your last colonoscopy/flex sig? _____ Result? _____

Type of Surgery	Year

Type of Surgery	Year

Current Medications: Do you take any blood thinners? Yes No _____

Name of Medication	Dose(mg)	Times per day

Name of Medication	Dose(mg)	Times per day

Allergies: Are you allergic to latex? Yes No

Name	Reaction

Name	Reaction

Tobacco: Current Former Never Type: Cigarette Cigar Chewing Snuff Pipe Packs per day: _____ Years used: _____
Ever tried to quit? Yes No Year Quit: _____

Alcohol: No Yes Formerly Type: Beer Wine Liquor Frequency: Daily Weekly Occasionally Rarely Amount: _____

Street drugs: Type: _____ Frequency: _____ Last use: _____

Caffeine: No Yes Type: _____ How much? _____

Employer: _____ Occupation: _____

Status: Married Single Divorced Widow/er Partner Children: Number of sons: _____ Number of daughters: _____

Name: _____ Account #: _____

Family History: Please list medical problems of your close family members along with cause and age of death.

	Age		Medical Problems	Cause of death
	Alive	@Death		
Mother				
Father				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				
Brother/Sister (circle one)				

Do you have other family members with a history of colorectal, gynecologic, or breast cancer? _____

Symptoms: Check Yes or No for any symptoms you currently have or have had in the past 6 months.

<p>Constitutional</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Malaise</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Loss</p> <p>HEENT</p> <p><input type="checkbox"/> <input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Nasal congestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p>Respiratory</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough up blood</p> <p>Cardiovascular</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations</p>	<p>Gastrointestinal</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Dark/black stool</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Reflux</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p>Genitourinary</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary incontinence</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary retention</p> <p>Reproductive</p> <p><input type="checkbox"/> <input type="checkbox"/> Penile/vaginal discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexual dysfunction</p>	<p>Metabolic/Endocrine</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> <input type="checkbox"/> Heat intolerance</p> <p>Neurological</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> <input type="checkbox"/> Vertigo</p> <p>Psychiatric</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Increased stress</p> <p>Integumentary</p> <p><input type="checkbox"/> <input type="checkbox"/> Contact allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p>	<p>Musculoskeletal</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint pain</p> <p>Hematologic/Lymphatic</p> <p><input type="checkbox"/> <input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> <input type="checkbox"/> Enlarged lymph nodes</p> <p>Immunologic</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemicals in work place</p> <p><input type="checkbox"/> <input type="checkbox"/> Food allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Immunosuppression</p> <p><input type="checkbox"/> <input type="checkbox"/> Seasonal allergies</p>
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To the best of my knowledge, the above information is accurate and complete. I understand that it is my responsibility to inform my doctor of any health changes.

Signature

Date

Reviewed by

Date