3/08

Today's Date: ________________________

Last Name: ________________________ First Name: ________________________ Mid. Intl: ______

Street Address: ________________________ City: ________________________

State: __________ Zip Code: ________________ Email: ________________________

Home Phone: ________________ Bus Phone: ________________ Cell Phone: ________________

Age:______ Date of Birth ____________ Gender ______ Social Security #: ________________

Marital Status: ________________ Spouse's Full Name: ________________________

Fathers' First Name: ________________________ Mother's First Name: ________________________

Your Occupation: ________________________ Employer's Name: ________________________

Employer's Address and Phone: ____

Spouse/Parent Employer Name,Address,Phone: ____

Emergency Contact: Name ________________ Phone ________________ Relationship __________

Which physician referred you to this practice? (Name, Address, Phone) ________________________

____

Who is your primary care physician: (Name, Address, Phone) ________________________

____

Any other doctors treating you at this time: ____

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

________________ Relationship: __________ ________________ Relationship: __________

________________ Relationship: __________ ________________ Relationship: __________

Primary Insurance Carrier:

Name: ________________________________

Address: ________________________________

Phone #: ________________________________

Policy Holder Relationship to You: ________________

Policy Holder Name: ________________________

Date of Birth: ________________ Gender: __________

SS# ________________________________

Policy ID# ________________ Group # ____________

Secondary Insurance Carrier

Name: ________________________________

Address: ________________________________

Phone #: ________________________________

Policy Holder Relationship to You: ________________

Policy Holder Name: ________________________

Date of Birth: ________________ Gender: __________

SS# ________________________________

Policy ID# ________________ Group # ____________

I understand that unless other arrangements are made in advance or where applicable federal or state laws supersede, all fees are the responsibility of the patient and are due at the time of service.

I authorize release of any medical or other information necessary to process medical claims for professional services rendered by this office and its health care providers.

I authorize the release of any of my medical information to any of my other doctors to ensure quality care, as well as those individuals I have listed above as authorized to have access to my medical information.

Patient Signature: ____ **Date:** ________________

CRSA
Colon & Rectal Surgical Associates of L.I. P.C.

NAME: ______________________ **DATE OF BIRTH:** ______________

Reason for Visit: ______________________

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- ❑ Rectal Bleeding ______________
- ❑ Rectal Pain ______________
- ❑ Diarrhea ______________
- ❑ Constipation ______________
- ❑ Itching/Burning ______________
- ❑ Change in Bowel Habits ______________
- ❑ Protrusion/Swelling ______________
- ❑ Fecal Incontinence ______________
- ❑ Discharge ______________
- ❑ Abdominal Pain ______________
- ❑ Irritable Bowel Syndrome ______________
- ✶ How often do you move your bowels ______________
- ❑ Colonoscopy ____________ When ____________ Doctor ____________

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

- ❑ Colon Cancer ______________
- ❑ Colon Polyps ______________
- ❑ Diverticulosis ______________
- ❑ Diverticulitis ______________
- ❑ Ulcerative Colitis ______________
- ❑ Crohn's Disease ______________
- ❑ Anal or Rectal Surgery ______________
- ❑ Heart Disease (Angioplasty, MI, etc.)______________
- ❑ Heart Valve Disease ______________
- ❑ Hypertension ______________
- ❑ Pace Maker______________
- ❑ Defibrillator ______________
- ❑ Seizure/Stroke______________
- ❑ Lung Disease ______________
- ❑ Liver Disease/Hepatitis ______________
- ❑ Stomach Ulcer ______________
- ❑ Kidney Disease ______________
- ❑ Phlebitis ______________
- ❑ Thyroid Disease ______________
- ❑ Diabetes ______________
- ❑ Bleed Easily ______________
- ❑ Psychiatric ______________
- ❑ Bladder Problem ______________
- ❑ Prostate Problems ______________
- ❑ Gynecological Problems ______________
- ❑ Personal History of Cancer ______________

FAMILY HISTORY / RELATIONSHIP-IE: MOTHER, FATHER ETC. (CHECK ALL THAT APPLY)

- ❑ Colon or Rectal Cancer ______________
- ❑ Colon or Rectal Polyps______________
- ❑ Crohn's Disease ______________
- ❑ Ulcerative Colitis ______________
- ❑ Other Cancer(s), Type ______________

CURRENT MEDICATIONS (Prescription / Over The Counter / Vitamins / Nutritional Supplements

______________________ ______________________
______________________ ______________________
______________________ ______________________

Do you take antibiotics prior to surgical or dental procedures? YES ____ NO ____

❑ ***Continued on Back***

LIST ALLERGIES (Medications / X-Ray Dye / Latex / Local Anesthesia, Etc.

______________________ ______________________
______________________ ______________________

SURGICAL HISTORY (List all operations and year performed)

______________________ ______________________
______________________ ______________________
______________________ ______________________

HOSPITALIZATIONS (List all not shown above)

______________________ ______________________
______________________ ______________________

SOCIAL HISTORY

Do you smoke? Yes ___ No ___ Packs Per Day ______Do you drink alcohol? Yes ___ No ___ Drinks Per Day ___________

______________________ __________ ______________________ __________
PATIENT SIGNATURE DATE PHYSICIAN'S SIGNATURE DATE

See Back of Form

Patient Name: ______________________________ Date: ____________________

FOR PATIENT:

CURRENT MEDICATIONS Continued (Prescription / Over The Counter / Vitamins / Nutritional Supplements

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

FOR PHYSICIAN:

EDUCATIONAL NEEDS ASSESSMENT

Any Barriers to Learning? ❑ **NO** ❑ **YES** - If Yes, check applicable areas below:

- ❑ Language
- ❑ Cultural
- ❑ Cognitive
- ❑ Behavioral

Areas of Need:

- ❑ Post Procedure Care
- ❑ Medication Reaction
- ❑ Pre-Op / Post Op Instruction
- ❑ Informed Consent
- ❑ Other:

Education Provided To:

- ❑ Patient
- ❑ Spouse
- ❑ Home Care Nurse
- ❑ Other: ______________________________