



NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

**PAIN ASSESSMENT**

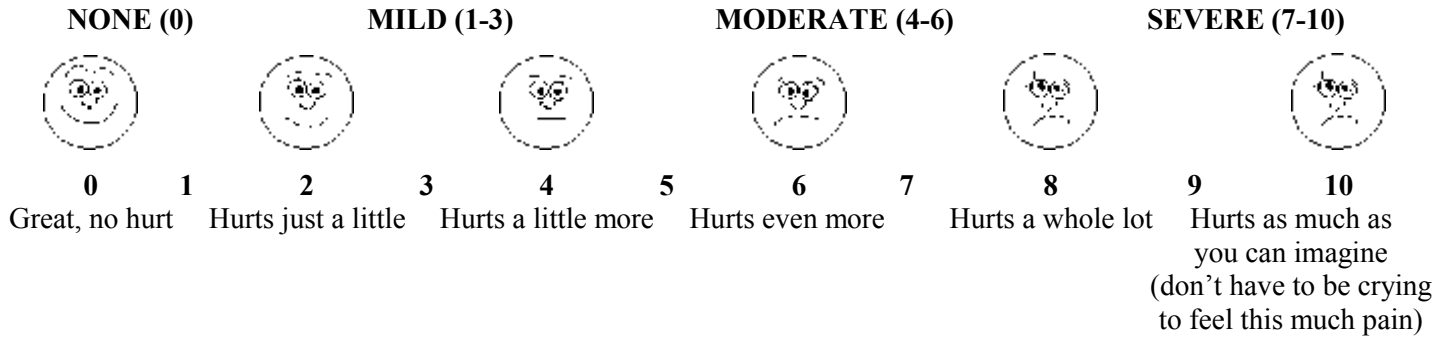
Please indicate **location** of pain, describe **quality and frequency** of pain, **circle #** that reflects degree of pain (even if no pain.)

**LOCATION OF PAIN** \_\_\_\_\_

**DESCRIBE PAIN**    Sharp    Dull    Burning    Other \_\_\_\_\_

Always    Sometimes    \_\_\_\_\_ x week    With bowel movements    Other: \_\_\_\_\_

Use the chart below and circle the number that best describes the amount of pain (or lack of pain) you are feeling now:



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

\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS WITH DOSES (Prescription / Over The Counter / Vitamins / Nutritional Supplements)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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



Print Patient Name: \_\_\_\_\_

**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 \_\_\_\_\_
- Heart Murmur: \_\_\_\_\_
- Pace Maker \_\_\_\_\_
- Defibrillator \_\_\_\_\_
- Stroke \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- Seizure Disease \_\_\_\_\_
- Neurological Disease: \_\_\_\_\_
- Lung Disease \_\_\_\_\_
- Liver Disease/Hepatitis \_\_\_\_\_
- Stomach Ulcer \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Phlebitis \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Bleed Easily \_\_\_\_\_
- Psychiatric \_\_\_\_\_
- Bladder Problem \_\_\_\_\_
- Prostate Problems \_\_\_\_\_
- Gynecological Problems \_\_\_\_\_
- Musculoskeletal/Prosthetic Joints: \_\_\_\_\_
- Vision/Hearing Problems \_\_\_\_\_
- Personal History of Cancer \_\_\_\_\_
- Any Chance of Pregnancy? \_\_\_\_\_
- Date Last Menstrual Period: \_\_\_\_\_

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

- Colon or Rectal Cancer \_\_\_\_\_
- Colon or Rectal Polyps \_\_\_\_\_
- Other Cancer(s), Type \_\_\_\_\_
- Crohn's Disease \_\_\_\_\_
- Ulcerative Colitis \_\_\_\_\_

**SOCIAL HISTORY**

Do you use Tobacco?     No     Yes If Yes amount per day \_\_\_\_\_     Cigarettes or Cigars     Smokeless Tobacco.  
 Do you drink Alcohol?     No     Yes If Yes, number of drinks \_\_\_\_\_     per week     per day

**SURGICAL HISTORY (List all with year performed)**

**HOSPITALIZATIONS (List all not shown to the left)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior Anesthesia Difficulties:  Yes  No

Blood Relatives w/Anesthesia Difficulties:  Yes  No

(X) \_\_\_\_\_

**PATIENT SIGNATURE** **DATE**

**\*\*FOR NURSES/PHYSICIANS ONLY\*\***

**VITAL SIGNS**

B/P \_\_\_\_\_      Pulse \_\_\_\_\_      Height \_\_\_\_\_      Weight \_\_\_\_\_

**\*\*FOR PHYSICIAN ONLY\*\***

**EDUCATIONAL NEEDS ASSESSMENT**

Any Barriers to Learning?  NO       YES If YES, Areas of Need: Check applicable:  
 Language     Cultural     Cognitive     Behavioral     Post Procedure Care     Medication Rxn     Informed Consent.     Post-Op Instruct.  
 Education Provided To:     Patient     Spouse     Home Care Nurse     Other: \_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S SIGNATURE** **DATE**



**OUR PRACTICE FINANCIAL POLICY**

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about this policy, please discuss them with our Billing Coordinator. We are dedicated to providing the best possible care and the highest level of service and regard your complete understanding of our financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or with your health insurance carrier, full payment is due at the time of service. For your convenience, we accept, CASH, CHECKS, VISA & MASTERCARD.

**Medicare Patients:**

- We are participating providers of Medicare. We will be collecting your 20% Medicare coinsurance and/or deductible (if applicable) at the time of your visit, **UNLESS** your secondary carrier is automatically “crossed-over” by Medicare. In that case, if your secondary carrier’s reimbursement does not cover the co-insurance in full, you will be billed for the balance.
- If you have recently joined or are planning to join a Medicare HMO for your health insurance coverage, it is imperative that you let our office know as soon as possible. At this time we do not participate in any Medicare HMOs.

**Managed Care Patients:**

**REFERRALS:**

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits and with whom we are participating providers. **The following requirements will need to be adhered to:**

- If a **referral form** or **referral authorization** is required, you must present it to the receptionist at the time of your initial appointment. If you are scheduled for follow up visits, **it is your responsibility to make sure that your ongoing referral is valid.**
- If you choose to use your benefits “out of network” (without a referral from your PCP), you will be responsible for any associated out of pocket expenses, which will be due at time of service. Questions can be directed to the Billing Manager.
- If you do not have out of network benefits and you opt to be seen without a referral authorization, you will be required to pay for the services in full.

**CO-PAYMENTS:**

- *Please be prepared to pay your co-payment/coinsurance at the time of your visit.*

**PREVENTATIVE AND ROUTINE CARE:**

Due to the nature of our specialty, we strongly advocate routine screenings and preventative care. Some managed care companies (depending on the type of contract negotiated by your employer group) will cover preventative services, while others do not. ***In the event that your contract does not cover these types of services, you will be responsible for payment.***

**A NOTE ABOUT OUR FEES:**

You may have been quoted a fee for your consultation or office visit. Please be aware that until the doctor examines you and discusses your medical needs, we cannot determine prior to your visit whether or not you will require any special diagnostic or therapeutic care during your visit. If you do require a diagnostic or therapeutic procedure, this service will be billed in addition to the fee for the office visit. Please feel free to ask questions about the care your doctor recommends.

**It is the responsibility of the patient to know the terms of his or her insurance coverage.** Please call your carrier if you have any questions about your benefits. Deductible or co-insurance amounts withheld from our payment are the responsibility of the patient. If you have any questions about this, please speak to our Billing Coordinator.

If we are denied payment due to lapse of coverage, misrepresented information provided to us at any time, failure to notify us of a change in your insurance information, or your failure to follow the rules of your insurance contract, you will be responsible for our regular fee.

**I have read and understand the above stated financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended where necessary by the practice.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Today’s Date

\_\_\_\_\_  
Print Name



As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

**This waiver authorizes ProHEALTH Care Associates to send/give my medical information as noted:**

Leave a voice mail recording including my Personal Health Information on my home/cell phone:

Yes       No

Leave a voice mail recording including my Personal Health Information on my business phone:

Yes       No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results:

Yes       No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet):

Yes       No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results:

Yes       No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information:

Yes       No

Name of Personal Representative: \_\_\_\_\_

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On this date \_\_\_\_\_, I received and reviewed ProHEALTH's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify ProHEALTH Care Associates in writing, by certified mail, of requested changes.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
Telephone Number



***DIRECTIONS: TO OUR NEW LAKE SUCCESS OFFICE***

**3 VERMONT DRIVE – LAKE SUCCESS QUADRANGLE ~ LAKE SUCCESS, NY 11042**  
**PHONE: (516) 608-6848 FAX (516) 570-4046**

**FROM THE NORTHERN STATE:** Exit **25**, southbound, toward Lakeville Rd/New Hyde Park Rd, merging onto Lakeville Rd. Turn **LEFT** at Marcus Avenue. Take **LEFT** and Third Traffic Light into the Lake Success Quadrangle. At Stop Sign make **RIGHT** and travel to Vermont Drive. Make **Left** onto Vermont Drive.

**WEST BOUND - LONG ISLAND EXPRESSWAY:** Exit **34** to New Hyde Park Rd. Make **Left** onto New Hyde Park Rd. Make a **Right** at the second blue & gray Lake Success Quadrangle sign. Follow signs to “All Other Buildings” until you find Vermont Drive. Make **left** onto Vermont drive.

**EAST BOUND – LONG ISLAND EXPRESSWAY:** Exit **34** to New Hyde Park Rd. Make **Right** onto New Hyde Park Rd. Make a **Right** at the second blue & gray Lake Success Quadrangle sign. Follow signs to “All Other Buildings” until you find Vermont Drive. Make **left** onto Vermont drive.

For Map to the Lake Success Quadrangle, visit [www.prohealthcare.com](http://www.prohealthcare.com).

***DIRECTIONS TO COLON & RECTAL SURGICAL: Huntington Office***

**200 WEST CARVER ST., SUITE 5, HUNTINGTON, NY 11743 (631) 423-5070**

**FROM THE NORTHERN STATE:** EXIT 40N to merge onto RT-110 N toward HUNTINGTON. Travel approx.. 5.5 miles north bound. TURN **LEFT** at W. CARVER ST. (before 25A/No. Blvd.) Pass two Stop Signs. Building will be on your **LEFT**. Parking available in lot.

**FROM THE LONG ISLAND EXPRESSWAY:** EXIT 49N toward RT-110 N / HUNTINGTON Travel northbound on RT 110, approx. 6 mi. TURN **LEFT** at W. CARVER ST. (before 25A/ No. Blvd.) Pass two Stop Signs. Building will be on your **LEFT**. Parking available in lot.

**ALTERNATE FROM NORTHERN STATE OR LIE:** NORTHERN STATE to EXIT 42 N (DEER PARK AVE.) Or LIE/495 to EXIT 51 N (DEER PARK AVE.) Travel north bound on DEER PARK AVE, over RT 25 (Jericho Tpke.) Continue until you reach 25A/NORTHERN BLVD. Make **LEFT** on 25A/MAIN ST. Continue **WEST** and cross over RT 110 / NY AVE. At fourth traffic light make a **LEFT** onto PROSPECT AVE. Make **RIGHT** at the Stop Sign onto W. CARVER. Building is immediately to the left. Make **LEFT** into parking lot.

**FROM NORTHERN BLVD.** If traveling **EAST BOUND**, continue on 25A past the village of Cold Spring Harbor. The road will bend. The next town will be Huntington Village. Shortly after entering Huntington Village, make **RIGHT** onto PROSPECT AVE. (see Library) then make **RIGHT** at first Stop Sign onto W. CARVER. Building is immediately to the **LEFT** and make **LEFT** into Parking Lot.

**NOTE: Building numbers do not run consecutively on West Carver**  
**Follow directions above and you can't miss it!**