COLON & RECTAL SURGERY ASSOCIATES

PATIENT INFORMATION

"PLEASE PRINT" *and fill in ALL spaces*

PATIENT NAME: _____DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: ( ) _____- _____ CELL#: ( ) _____- _____ BEST DAYTIME PH# □ HOME / □ CELL

E-MAIL ADDRESS: _____ (for patient portal)

DOB _____/_____/_____ AGE: ____ SEX: M / F SS#: _____ MARITAL STATUS: M S W D

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____ WORK#_____

SPOUSE NAME: _____ CELL#: ( )_____ DOB: ____/_____/_____

REFERRING DR.: _____ PRIMARY DR. : _____

PHARMACY: _____ PH# or ADDRESS: _____

INSURANCE INFORMATION

IS INSURANCE IN PATIENTS NAME? YES / NO **IF NO, PLEASE LIST FOLLOW INFORMATION:**

PRIMARY CARDHOLDER'S NAME: _____ **EMPLOYER**: _____

SS#: _____-_____-_____ **DOB**: ____/_____/_____ **EMPLOYER PH#**: _____

HIPAA INFORMATION

List spouse, relatives (&/or) friends we may release your medical information to/whom may call on your behalf

Name: _____ Relation: _____ Phone: ( ) _____-_____

Name: _____ Relation: _____ Phone: ( ) _____-_____

_____ (READ & INITIAL) IT IS OUR OFFICE POLICY THAT YOUR COPAY, DEDUCTIBLE &/0R CO-INSURANCE BE PAID AT EACH OFFICE VISIT. IF SURGERY/PROCEDURE IS SCHEDULED WE REQUEST ANY DEDUCTIBLE &/OR COINSURANCE BE PAID BEFORE THE SURGERY/PROCEDURE. YOU ARE ALSO RESPONSIBLE FOR ANY BALANCES NOT PAID/COVERED BY YOUR INSURANCE COMPANY.

*****THIS OFFICE DOES NOT ACCEPT MEDICAID PRIMARY*****

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to:

SEAN MAYFIELD, M.D., JENNIFER SILINSKY, M.D., MATTHEW ZELHART, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure this payment.

_____ _____

SIGNATURE OF PATIENT OR LEAGAL GAURDIAN DATE

COLON AND RECTAL SURGERY ASSOCIATES

HISTORY AND PHYSICAL

Name: _____ **Age**_____ **Sex: M F**

Reason for visit: _____ **HT:** __ **WT:** ____

Referred by: _____ **Primary is Dr.** _____

I also see Dr. _____ **Dr**. _____

Occupation: _____ **Place of employment:** _____

Medications: (separate list if necessary)

1.) _____mg_____times/day 4.) _____ mg_____times/day
2.) _____mg_____times/day 5.) _____ mg_____times/day
3.) _____mg_____times/day 6.) _____ mg_____times/day

Medication Allergies & Reaction: _____

_____

Colon exam: Last colonoscopy:(year) _____ performed by _____Barium enema:(year)_____

If having colonoscopy specify type: Screening (preventive)_____ Diagnostic (previous polyps, etc.) _____

Family History: (blood relation): **Colon Cancer** _____ **Colon Polyps** _____

Breast Cancer: _____ **Uterine or Ovarian Cancer:** _____ **Other serious ailments:** _____

Past Surgeries: (with approx. date) _____

_____ _____ _____

_____ _____ _____

Social history: At home I live…. alone / with _____

Tobacco: No__ Yes ___/ ____ packs per day. **Alcohol:** No___ Yes ___/ _____drinks/beers per week.

REVIEW OF SYSTEMS: CHECK ALL THAT APPLY

Gastrointestinal
- □ Bleeding with BMs
- □ Constipation
- □ Change in bowel habits
- □ Diarrhea
- □ Rectal pain
- □ Soiling/ Incontinence
- □ Heartburn
- □ Abdominal pain
- □ _____

Skin
- □ Bruise easily
- □ Rashes

Endocrine
- □ Diabetes
- □ Hypo/hyperthyroid
- □ Steroid use

General
- □ Fevers
- □ Chills
- □ Sweats
- □ Weight loss
- □ Bleeding history
- □ Immune Deficiency

Urinary
- □ Painful Urination
- □ Blood in Urine
- □ Air in Urine
- □ Recurrent Infections
- □ Incontinence
- □ Dialysis

Muscle/Joint
- □ Arthritis
- □ Weakness in _____

Respiratory
- □ Asthma
- □ Bronchitis
- □ Shortness of breath
- □ Productive cough

Cardiovascular
- □ High Blood Pressure
- □ Heart Attack
- □ Irregular Heart Beat
- □ Rapid Heart Beat
- □ Mitral Valve Prolapse
- □ Valve Disease
- □ Leg Swelling

Neurological
- □ Permanent stroke
- □ Transient stroke
- □ Seizures

Cancer Treatment
- □ Chemo □ Radiation (area treated & year)

_____

_____

Blood Disorders:
- □ HIV/AIDS

Reproductive

(men only)
- □ Erectile dysfunction

(women only)
- □ Hysterectomy
- □ Childbirth # children _____
- □ Difficult delivery (tearing)
- □ C-section: #_____
- □ Still Menstruating

Other Medical Problems: _____

_____

_____ _____

PATIENT'S SIGNATURE **DATE**

Reviewed with patient and agree with above

DATE: _____ _____

Physician Signature

□ S. MAYFIELD, MD □ J. SILINSKY, MD
□ M. ZELHART, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SEAN MAYFIELD, M.D. JENNIFER SILINSKY, M.D. MATTHEW ZELHART, M.D.

Notice to our Patients:

We are required to provide you with a copy of our Notice of Privacy Practices upon request, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign the acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation it was not possible to obtain an acknowledgement.

□ We weren't able to communicate with the patient.

□ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.