PATIENT REGISTRATION FORM

WELCOME TO OUR PRACTICE

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
PLEASE PRINT. *ALL INFORMATION WILL BE CONFIDENTIAL.*

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ **AGE**_____ **DATE OF BIRTH**_____

ADDRESS_____ **SEX**_____ **MARITAL STATUS**_____

CITY_____ **STATE**_____ **ZIP**_____ **EMAIL ADDRESS:** _____

HOME PHONE_____ **REFERRED BY WHOM**_____

CELL PHONE _____ **PRIMARY PHYSICIAN**_____

SOCIAL SECURITY #_____ **PERMANENT ADDRESS (IF DIFFERENT)**

EMPLOYER_____ **ADDRESS**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

CITY_____ **STATE**_____ **ZIP**_____ **PHONE #**_____

WORK PHONE_____ **OCCUPATION**_____

PHARMACY NAME & PHONE_____

WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS UNDER FEDERAL GUIDELINES. IF YOU CHOOSE "I PREFER NOT TO ANSWER"
PLEASE BE ASSURED THAT NO ADVERSE ACTION WILL BE TAKEN BY ANYONE IN THIS OFFICE.

****RACE** _____ ****ETHNICITY** _____ **LANGUAGE** _____ **I PREFER NOT TO ANSWER** _____****

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME_____ **BIRTH DATE**_____

SOCIAL SECURITY #_____ **RELATION TO PATIENT**_____

PERMISSION FOR VERBAL COMMUNICATIONS

I permit Center for Colorectal Disease of Arizona, its physicians, nurses and other personnel to discuss health, medical, and/or billing information, in person or by telephone, with the following individuals listed below. (List individuals and state the person's relationship to the patient):

OR

I decline to give a name at this time ☐

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

This document does not permit release of any written health information to the individuals named above. Release of information under this document is limited to verbal discussions only.

If, at any time, I do not want verbal discussions to be permitted between Center for Colorectal Disease of Arizona **and any of the individuals named above, I must notify** Center for Colorectal Disease of Arizona **in writing or by calling (623)-440-6591 and speaking with the Practice Office Manager.**

***Signature**_____ **Date**_____

Medical History

Name_____ Today's Date_____

Reason for Today's Visit_____

HEALTH QUESTIONNAIRE Please check the boxes if you have ever been diagnosed with. Please read carefully and underline which type.

- ☐ Alcoholism
- ☐ Alzheimer
- ☐ Anxiety
- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Disorders or Anemia
- ☐ Bronchitis (Current)
- ☐ Cancer-specify_____
- ☐ Cataracts (list surgery below)
- ☐ Colitis
- ☐ Colonic Polyps
- ☐ Crohn's Disease
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (type1/type 2)
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Fibrocystic Breast Disease
- ☐ Fissure
- ☐ Gallstones
- ☐ Glaucoma
- ☐ GERD
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypothyroidism/Hyper
- ☐ Incontinence (fecal/urinary)
- ☐ Irregular Heart Beat-specify_____
- ☐ Kidney Disease/Stone
- ☐ Liver Disease/Hepatitis
- ☐ Mental Illness-specify__
- ☐ Migraines/Headaches
- ☐ Pneumonia (current)
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Gastric Ulcers
- ☐ Urine Infections

☐ Other Medical History _____

Current Problems?

	Yes	No		Yes	No		Yes	No
Weight Loss/Gain	___	___	Joint Pain	___	___	Change in bowels	___	___
Fever	___	___	Joint swelling	___	___	Constipation	___	___
Fatigue	___	___	Skin rash	___	___	Abdominal Pain	___	___
						Diarrhea	___	___
Hearing change	___	___	Headaches	___	___	Rectal Bleeding	___	___
Nose bleeds	___	___	Dizziness	___	___	Dark stools	___	___
Visual change	___	___	Insomnia	___	___			
Sore throat	___	___				Rectal Pain	___	___
						Rectal Burning	___	___
Chest Pain	___	___	Urinary frequency	___	___	Rectal Itching	___	___
Shortness of breath	___	___	Burning	___	___	Fecal Incontinence	___	___
Wheezing	___	___	Blood in urine	___	___	Nausea	___	___
						Vomiting	___	___

LIST ALL THE MEDICATIONS, DOSAGE AND FREQUENCY TAKEN

If you have a copy of your list of medications, please give a copy to the front desk.
(If more space is needed please ask the front desk for another form.

Medication Name	Dosage (mg)	Frequency (daily, tablets or capsules)

List more on the back side of this sheet. Thank You.

Medication Allergies and reactions:_____

Type of Allergy: **Latex** **Iodine** **Contrast**

HEALTH SCREENING

Have you ever had a mammography? (Indicate date and results) _____

Have you ever had a colonoscopy/flexible sigmoidoscopy? (Indicate date, results & MD)

_____

Have you ever had a prostate screening or PSA level? (Indicate date, results & MD)

_____

SURGICAL HISTORY & Years

- ☐ Appendectomy _____
- ☐ Breast Surgery _____
- ☐ Gall Bladder Removal _____
- ☐ Hernia Repair _____
- ☐ Cardiac Cath _____
- ☐ Pacemaker _____
- ☐ Heart Stent(s) _____
- ☐ Hysterectomy _____
  Complete or Partial
- ☐ Colon/Small Bowel _____
  (Specify) _____
- ☐ Previous Anorectal Surgery _____
  (Specify) _____

☐ Other Surgeries or Procedures & Years

_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

☐ Colorectal Cancer Family member affected: _____

Other Cancers in the family:

☐ Breast ☐ Prostate ☐ Stomach ☐ Uterine ☐ Ovarian ☐ Brain ☐ Bladder ☐ Other (Specify) _____

No family history of malignancies ☐

Any Falls in the last year? Yes No #____ injury with fall? _____

OTHER FAMILY MEDICAL DISORDERS

Specify: F-Father, M-Mother, B-Brother, S-Sister, D-Daughter, SS-Son

Bleeding Problems	_____	Kidney Disease	_____	Mother- Alive or Deceased
Asthma	_____	Colonic Polyps	_____	Cause of death_____
Hypertension	_____	Diverticulitis disease	_____	Father- Alive or Deceased
Hypercholesterolemia	_____	Ulcerative Colitis	_____	Cause of death_____
Diabetes	_____	Crohn's Disease	_____	
Heart Attack	_____	Colitis	_____	

SOCIAL HISTORY

☐ Single ☐ Married ☐Divorced/Separated ☐Widowed

Work ☐Yes ☐No ☐Retired Occupation: _____

Smoke: ☐ Yes ☐ No ☐ Former **Pack/Day** _____

Social Drugs: _____

Last Menstrual Period ____/____/_____

Alcohol: ☐ Yes ☐ No

☐ Monthly #____ ☐ Daily #____ ☐ Socially #____

Height: _____ft _____in **Weight:** _____lbs

Any dietary restrictions: ☐ Yes ☐ No

Explain: _____

OBSTETRICAL AND GYNECOLOGICAL HISTORY

Pregnancies #_____ Children #_____

Last Pap Smear/Pelvic Exam _____

Deliveries #_____ C-section _____

Vaginal delivery _____ Forceps _____ Episiotomy _____

ALL PATIENTS PLEASE READ AND SIGN

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize Center for Colorectal Disease of Arizona to release any information necessary to file a claim with my insurance company and request that payments under my insurance plans be made directly to Center for Colorectal Disease of Arizona for any services furnished to me. I understand that I am financially responsible for balances not covered by my insurance carrier.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Self-Pay patients understand that they are financially responsible for all services provided by Center for Colorectal Disease of Arizona. If necessary, I will set up a payment plan with the office manager.

Financial Arrangements

We offer the following methods of payment: Discover, Visa, Master Card and Personal Check. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance **prior** to your appointment.

FMLA Forms

We are happy to complete any FMLA Forms as needed. There is a $25 charge for each & every form to be completed and is due prior to the form being completed. We have 14 days to complete the form.

Appointments

There will be a $25.00 charge for missed appointments and procedures. (Appointments not cancelled more than 24 hours in advance or "no-shows")

Acknowledgement of Center for Colorectal Disease of Arizona's **Office Policy**

I have been presented with a copy of Center for Colorectal Disease of Arizona's "***Office Policy***". I understand the contents and I agree to its terms.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Center for Colorectal Disease of Arizona's ***"Notice of Privacy Policies"***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restriction(s) concerning my personal medical information:

INFORMED CONSENT

When you become a patient in this office, certain low risk procedures will be performed. As with all medical procedures, there are certain risks involved. Anoscope, proctoscopy, flexible sigmoidoscopy, polypectomy, hemorrhoidal ligation, drainage of abscess and laser surgery are all low-risk procedures often performed in this office. These will all be explained to you in consultation before your examination. If you have questions at any time about what is being done to you, please ask the doctor or office personnel immediately.

Patient Signature: _____ Date: _____