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 or in writing, 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. ____________	____________	____________

If, at any time, I do not want verbal discussions to be permitted between Colorectal Disease of Arizona and any of the individuals named above, I must notify 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
Weight Loss/Gain	___	___
Fever	___	___
Fatigue	___	___
Hearing change	___	___
Nose bleeds	___	___
Visual change	___	___
Sore throat	___	___
Chest Pain	___	___
Shortness of breath	___	___
Wheezing	___	___
Joint Pain ___	___	___
Joint swelling	___	___
Skin rash	___	___
Headaches	___	___
Dizziness	___	___ ___
Insomnia	___	___
Urinary frequency	___	___
Burning	___	__ ___
Blood in urine	___	___
Change in bowels	___	___
Constipation	___	___
Abdominal Pain	___	___
Diarrhea	___	___
Rectal Bleeding	___	___
Dark stools	___	___
Rectal Pain	___	___
Rectal Burning	___	___
Rectal Itching	___	___
Fecal Incontinence	___	___
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

Height: ________ft _______in **Weight:** ___________lbs

Work ☐ Yes ☐ No ☐ Retired Occupation:_________________

Any dietary restrictions: ☐ Yes ☐ No

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

Explain: ___________________________

Social Drugs: _____________________________

Alcohol: ☐ Yes ☐ No

☐ Monthly #_____ ☐ Daily #_____ ☐ Socially #_____

Obstetrical and Gynecological History

Pregnancies #__________ Children #___________

Last Menstrual Period ____/____/______

Deliveries #__________ C-section _____ Vaginal delivery _____

Last Pap Smear/Pelvic Exam ___________

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 American Express. 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 Office Policy

I have been presented with a copy of Center for Colorectal Disease of Arizona "***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 ***"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. Anoscopy, 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: ____________________

Center for Colorectal Disease of Arizona

Phone: 623-440-6591 Fax: 623-440-8142

Your provider may perform an Anoscopy procedure as part of your evaluation, this may be necessary to obtain a diagnosis and for treatment purposes. This will be billed to your insurance; however, Insurance plans consider this a surgical procedure it is a separate fee from the office visit and the Insurance may apply this fee towards your deductible/coinsurance so you may be responsible for an additional amount after the claim is processed.

An Anoscopy is a simple procedure where a small instrument (anoscope) is inserted into the rectum. This allows your provider to identify any abnormalities in the anorectal area. The procedure is very brief, with minimal discomfort. Your provider will review this further with you if this needs to be performed.

Patient Name: ___________________________________

Patient DOB: ____________________________________

Patient Signature: ________________________________ Date: ___________________