Advocare Colon & Rectal Surgical Specialists

DATE:_____

NAME:_____ ADDRESS:_____

_____

SOCIAL SECURITY # _____ _____

DOB:_____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

RACE: _____ PREFERRED LANGUAGE _____

TELEPHONE #:_____ CELL #:_____

PRIMARY CARE PHYSICIAN NAME: _____

EMERGENCY CONTACT PERSON AND NUMBER:_____

PHARMACY NAME & PHONE #:_____

It is important that patients 65 and older have a history and physical on file with their primary care physician within 90 days of their open access colonoscopy. This can be easily obtained through your primary care provider and forwarded to our colonoscopy scheduling department. Have you met the criteria?

☐ Yes ☐ No Date of Exam: _____ Physician:_____

Please check yes or no to the following medical history questions;

HEART DISEASE

☐ Yes ☐ No Do you take blood thinning medications? (aspirin, Coumadin, Effient, Plavix, Pradaxa, Xarelto)

☐ Yes ☐ No Coronary artery disease/angina/heart attack?

☐ Yes ☐ No Congestive heart failure?

☐ Yes ☐ No Valvular heart disease/artificial heart valve?

LUNG DISEASE

☐ Yes ☐ No Emphysema, COPD, asthma, bronchitis requiring regular medical therapy or home oxygen

☐ Yes ☐ No Sleep apnea Do you use a CPAP Machine? ☐ Yes ☐ No, What is the setting? _____

GENERAL HEALTH

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Kidney disease

☐ Yes ☐ No Stroke/TIA

☐ Yes ☐ No Diabetes

GENERAL HEALTH CONTINUED **NAME:**_____

☐ Yes ☐ No Liver disease, hepatitis, bleeding disorder?

☐ Yes ☐ No Do you take antibiotics when going for dental work?

☐ Yes ☐ No Have you had a joint replacement within the last year?

☐ Yes ☐ No Have you ever had a complication with anesthesia? If Yes, what complications?

Complications;_____

HEIGHT: _____**WEIGHT:** _____

GASTROENTEROLOGY

☐ Yes ☐ No Do you have a personal history of intestinal or colon surgery? When _____

☐ Yes ☐ No Do you see blood in your bowel movement?

☐ Yes ☐ No Do you have a change in bowel habits?

☐ Yes ☐ No Do you have relatives with Colon Cancer? Who?_____

Please list any allergies

Please list any previous surgeries or procedures and dates

Please list any active medical problems:

Please list any medications you are taking and the dosage:

Please return this 3 page completed form and
A FRONT & BACK COPY OF YOUR INSURANCE CARDS to our office. **Fax: 856-428-2718**
If there are no contraindications, you will be assigned to one of our physicians and set up for a colonoscopy. You may need a preliminary appointment if there are medical concerns identified that would need attention before scheduling the procedure.

NAME: _____

PRIMARY
INSURANCE _____

ID# _____ ADDRESS _____

_____

PHONE:_____

POLICY HOLDER/SUBSCRIBER:

NAME: _____

DATE OF BIRTH: _____

SECONDARY
INSURANCE _____

ID# _____ ADDRESS _____

_____

PHONE: _____

POLICY HOLDER/SUBSCRIBER:

NAME: _____

DATE OF BIRTH: _____

COMMERCIAL INSURANCE PATIENTS

I authorize the release of any medical information necessary to process all claims and authorize payment of medical benefits to Advocare Colon & Rectal Surgical Specialists for services rendered.

_____
Patient Signature

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advocare Colon & Rectal Surgical Specialists for any services furnished to me by that physician supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

_____
Patient Signature

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

NAME: _____ Date of Birth _____

- May we leave messages/detailed medical information on voicemail at either of these phone numbers?

☐ Yes ☐ No Home Phone: _____ ☐ Yes ☐ No Cell Phone: _____

- May we contact you at your place of employment? ☐ Yes ☐ No If so, may we leave a message? ☐ Yes ☐ No

If yes: Work Phone: _____ Extension: _____

- Do you have any particular person you wish to designate as your representative regarding surgical scheduling, receipt of medical information or billing issues? ☐ Yes ☐ No

If so, please provide: Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize **Advocare Colon & Rectal Surgical Assoc.** to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

SIGNATURE:_____ DATED: _____

WITNESSED BY: _____

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