

CHARLOTTE COLON & RECTAL SURGERY ASSOCIATES, P.A.

Account # _____ Today's Date _____

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____ Age _____ Sex: M / F _____ Marital Status (M,S,W) _____
(Circle One) # of Children _____

** WHO WERE YOU REFERRED BY: _____

YOUR Social Security #: _____ Your Employer _____ Your Cell Phone # _____
Your Occupation _____

Employer's Address _____ Work _____ Spouse's _____
(include street, city, state & zip code) Phone Number _____ Work Number _____

Spouse's Name _____ Spouse's Social Sec. No. _____ Spouse's _____
Employer _____

INSURANCE INFORMATION: Please present all insurance cards so we may make a copy for filing insurance.

****PRIMARY CARE PHYSICIAN OR FAMILY PHYSICIAN:** _____
(Name, address and phone number if available)

CURRENT MEDICATIONS-LIST ALL

<u>NAME & DOSE</u>	<u>NAME & DOSE</u>
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES TO MEDICATIONS

<u>NAME</u>	<u>REACTION</u>
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO LATEX? YES NO

What type of problem are you having? (Describe your symptoms)

Do you have currently, or have you had in the past, any of the conditions listed below?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	Colon or rectal cancer	___	___	Arthritis
___	___	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)	___	___	Neurologic illness
___	___	Diverticulitis	___	___	Psychiatric illness
___	___	Previous colon or rectal surgery	___	___	Easy bleeding or bruising
___	___	Previous abdominal surgery	___	___	Anemia
___	___	Previous anal surgery	___	___	Gallbladder disease or gallstones
___	___	Fevers	___	___	Liver disease or cirrhosis
___	___	Weight loss	___	___	Ulcer of the stomach or small intestine
___	___	Previous organ transplant	___	___	Diseases of the pancreas
___	___	Chest pain or angina	___	___	Do you smoke cigarettes? ___
___	___	Myocardial infarction (heart attack)	___	___	___ Packs/day
___	___	Palpitations or Arrhythmias or have a Pacemaker	___	___	Have you ever smoked cigarettes?
___	___	Previous heart surgery	___	___	Year Quit? ___
___	___	Hypertension (high blood pressure)	___	___	Do you drink alcohol? ___Drinks/wk. ___
___	___	Stroke	___	___	Have you ever been treated for alcoholism?
___	___	Claudication (poor blood flow to legs)	___	___	Have you ever used intravenous drugs?
___	___	Blood clot in the legs	___	___	Have you ever had a blood transfusion?
___	___	Blood clot in the lungs (pulmonary embolism)	___	___	
___	___	Asthma or Emphysema	___	___	
___	___	Pneumonia	___	___	
___	___	Kidney Failure/dialysis	___	___	
___	___	Urinary or prostate problems	___	___	
___	___	Impotence	___	___	
___	___	Diabetes	___	___	
___	___	Thyroid problems	___	___	
___	___	Have you ever taken steroids (Prednisone, etc.)	___	___	

FAMILY HISTORY:

Has anyone in your family had the following conditions?
___ ___ Colon polyps
___ ___ Colon or rectal cancer
___ ___ Inflammatory bowel disease (Crohn's or ulcerative colitis)
___ ___ Heart disease
___ ___ Stroke

PLEASE LIST ALL SURGERIES AND HOSPITALIZATIONS:

- (1) _____ (2) _____ (3) _____
- (4) _____ (5) _____ (6) _____

IN CASE OF EMERGENCY, WHOM DO WE CONTACT? (Other than spouse)

(Name) (Phone) (Relationship)

PHYSICIAN REVIEW
INITIALED: _____

PAYMENT AGREEMENT

- I agree to assign payment directly to Charlotte Colon & Rectal Surgery Associates, P.A., for both basic and major medical benefits payable to me under the conditions of my insurance.
- I understand that filing of insurance is a service only, and it is not a guarantee of payment.
- I understand it is my responsibility to obtain the necessary approval for office or physician services if my insurance requires preauthorization or precertification for those services.
- I understand that I am financially responsible for the full amount of my bill if my insurance does not pay. I understand that some insurances do not pay for what are considered routine or screening examinations. Medicare and some insurance companies do not pay for supplies. Therefore, I understand that payment for these services and supplies is my responsibility.
- This practice accepts Medicare assignment. I request that payment of authorized Medicare benefits be made on my behalf to Doctors Walker, Morrison, Jerby or Rosen for any services furnished me by that physician. 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 or the benefits payable for related services.
- I authorize this office to release any information acquired in the course of my treatment for insurance purposes, or to the referring physician, or to other physicians who are currently treating me.
- I request that payment of authorized Medigap benefits be made on my behalf to Charlotte Colon & Rectal Surgery Associates, P.A. for any services furnished to me by the physicians in the group. I authorize any holder of medical information about me to release to Medigap insurance any information needed to determine these benefits.
- I assign my insurance benefits to Charlotte Colon & Rectal Surgery Associates and understand that this form is valid for one year unless cancelled through written notice.
- I hereby acknowledge that I have been presented with a copy of Charlotte Colon and Rectal Surgery Associates, P.A. Notice of Privacy Practices as mandated by Federal law under HIPPA regulations.
- I authorize the following people to have access to my medical records:
_____ (Relationship) _____ (Relationship)
_____ (Relationship) _____ (Relationship)

AUTHORIZATION FOR EXAMINATION & TREATMENT

- I authorize the physicians of Charlotte Colon & Rectal Surgery Associates, P.A. to perform indicated diagnostic procedures such as flexible sigmoidoscopy, anoscopy, and proctoscopy as well as minor surgical procedures such as rubber band hemorrhoid therapy, injection of hemorrhoids, removal of thrombosed hemorrhoids, infrared coagulation of hemorrhoids, removal of tags, incision and drainage of abscesses, and other procedures where indicated. I understand these procedures may have risks of bleeding, infection, and pain. I understand that I may refuse any therapy offered.

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

DATE: _____ SIGNATURE: _____

PRINTED NAME: _____ MEDICARE #: _____