The Ultimate Care

Carolina Colorectal Surgery, PC

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Today's Date: _____

Patient Information:

Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Sex: [M] / [F] SSN: _____

Parent or Guardian (if minor patient): Last: _____ First: _____

Address: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Preferred Contact: Cell Home (please circle one)

Email address: _____

Ethnicity: [__] Hispanic or Latino [__] Non-Hispanic or Latino

Race: [__] Native American [__] Asian [__] African American [__] Caucasian [__] Hispanic or Latino

Referring Physician: _____ Phone #:_____

(Practice Name and Address) _____

Cardiologist: _____ Phone#: _____

(Practice Name and Address) _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information:

Primary Insurance: _____ ID Number: _____Group #: _____

Policy Holder Information check if same as above [ ]

Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Sex: [M] / [F] SSN: _____

Relation to the patient: [Spouse] [Parent] [Guardian] [Other]

Secondary Insurance: _____ ID Number: _____Group #:_____

Policy Holder: [Patient] [Same as Primary] [Other]

Medications:

Please list any medications you are currently taking. Include the dose if you know it. You can use the back of this page if you require more space. If you are not taking any medications select the box marked none.

[None]

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Name of medication: _____ Dose: _____

Allergies:

Please list any allergies you have below. You can use the back of this page if you require more space. If you do not have any allergies or are unsure select the box marked NKA.

[NKA]

Name of medication: _____ Reaction: _____

Name of medication: _____ Reaction: _____

Name of medication: _____ Reaction: _____

Preferred Pharmacy:

Please list your preferred pharmacy below. **Please make a note of which medications should go to each pharmacy if you use multiple pharmacies.

Name: _____ Address: _____

Name: _____ Address: _____

Medical Services Authorization and Payment Agreement:

I hereby authorize Carolina Colorectal Surgery to perform Medical Services.

I hereby agree that any insurance benefits associated with any services rendered by Carolina Colorectal Surgery or their representatives are hereby assigned to Carolina Colorectal Surgery

I FURTHUR AGREE THAT ANY PORTION OF THE BILL UNPAID IS MY RESPONSIBILITY.

I understand the following:

- It is my responsibility and not that of Carolina Colorectal Surgery to check my insurance policy for coverage and benefit information.
- Any services not covered by my insurance company are my responsibility.
- Co-pays are to be paid at check-in.
- Any bill unpaid after 30 days will be subject to a late fee of $20 per month until bill is paid.
- Any bill unpaid after 90 days will be subject to be turned into collections.
- Patients who miss an appointment without 24 hour notice will be charged a fee of $25.00.
- If you are scheduled for surgery and miss your pre-testing, your surgery will be cancelled and rescheduled for the next available time.
- All surgeries must be cancelled 1 week prior to the date of surgery or you will be charged a fee of $150.00
- All returned or cancelled checks will be charged a fee of $25.00.
- **Prescriptions and refills may take up to 48-72 business hours to process.**
- **All calls will be returned within 24 business hours.**

I have carefully read the above statements and am in complete understanding of them.

*Print Name: _____

*Signature: _____ *Date: _____

Authorization for Use and Disclosure of Protected Health Information:

It is our policy at Carolina Colorectal Surgery to never release your medical records to anyone. However, we understand the need to allow certain access to protected information at your request. In order to be able to release any information regarding your care to anyone (spouse, family, significant other, etc…) you will need to complete the form below. If not just select the box below.

I do not want my information shared with anyone. [ ]

The below named person(s) is/are given authorization to my medical records. I understand that I can revoke my authorization at any anytime. I understand that the request for revocation will have to be given to Carolina Colorectal Surgery in writing. I further understand that any information released prior to receiving the request for revocation cannot be contested.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing, I authorize Carolina Colorectal Surgery to use and/or disclose certain protected health Care information.

Patient's Name: _____

Signature: _____ Date: _____

HIPPA Agreement:

I understand that, under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. Available upon request in the office in print form and is also available at https://apollourgentcare.com/notice-of-privacy-practices. I have reviewed or have chosen not to review such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied or have chosen not to study the Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I am able to revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Patient Name_____ DOB_____ Today's Date_____

REVIEW OF CURRENT SYMPTOMS

(Please circle all that apply within the last 30 days)

__No Current Symptoms

General

___Chills

___Depression

___Dizziness

___Fainting

___Fever

___Forgetfulness

___Headache

___Loss of Sleep

___Loss of Weight

___Nervousness

___Numbness

___Sweats

___Vomiting

___Weight Gain

Gastrointestinal

___Appetite poor

___Bloating

___Bowel Changes

___Constipation

___Diarrhea

___Excessive Thirst

___Gas

___Hemorrhoids

___Indigestion

___Nausea

___Rectal Bleeding

___Stomach Pain

___Lack of Bladder Control

___Vomiting Blood

___Excessive Hunger

___Blood in Stool

Skin

___Bruise Easily

___Hives

___Itching

___Change in Moles

___Rash

___Scars

___Sore that won't heal

Genito-Urinary

___Blood in Urine

___Painful Urination

___Frequent Urination

Eye, Ear, Nose, Throat

___Bleeding Gums

___Blurred Vision

___Crossed Eyes

___Difficulty Swallowing

___Double Vision

___Earache

___Ear Discharge

___Hay Fever

___Hoarseness

___Loss of Hearing

___Nosebleeds

___Persistent Cough

___Ringing in Ears

___Sinus Problems

___Vision-Flashes

___Vision-Halos

WOMEN Only

___Nipple Discharge

___Abnormal Pap Smear

___Bleeding Between Periods

___Breast Lump

___Extreme Menstrual Pain

___Hot Flashes

___Painful Intercourse

___Vaginal Discharge

MEN Only

___Breast Lump

___Erection difficulties

___Lump in Testicles

Penis Discharge

___Sore on Penis

Cardiovascular

___Chest Pain

___High Blood Pressure

___Irregular Heart Beat

___Low Blood Pressure

___Poor Circulation

___Rapid Heartbeat

___Swelling of Ankles/Edema

___Varicose Veins

Muscle/Joint/Bone

<u>Pain, weakness, numbness in;</u>

___Neck/Shoulders

___Arms

___Back

___Feet/Legs

___Hands

___Hips

Patient Name_____ DOB_____ Today's Date_____

Please list any other symptoms you have:

_____

PAST MEDICAL CONDITIONS (Please CIRCLE any conditions you have ever had in the past)

___ No Past Medical History	___Heart Disease	___Urinary Tract Infection	___Anxiety
___GERD/Reflux Disease	___Heart Attack	___Kidney Disease	___Depression
___Constipation	___Pacemaker	___Kidney Cancer	___Psychiatric Care
___Diarrhea	___Heart Stent #___	___High Blood Pressure/HTN	___Bulimia
___Crohn's Disease	___Heart ByPass/CABG	___High Cholesterol	___Anorexia
___Irritable Bowel Syndrome	___A-FIB/Atrial Fibrillation	___Anemia	___History of Suicide Attempt
___Diverticula Disease	___Irregular Heartbeat	___Thyroid Disease	___Alcoholism
___Ulcerative Colitis	___Heart Murmurs	___Goiter/Enlarged Thyroid	___Chemical Dependency
___Peptic Ulcer	___Congestive Heart Failure	___Diabetes	___Liver Disease
___GI Bleeding	___Stroke/TIA	___Bleeding Disorder	___Liver Cancer
___Hemorrhoids	___Seizures	___AIDS/HIV Positive	___Cirrhosis
___Appendicitis	___Neurological Disorders	___ Arthritis/Osteoarthritis	___Fatty Liver
___Gallstones	___Multiple Sclerosis	___ Rheumatoid Arthritis	___Hepatitis
___Celiac Disease	___Epilepsy	___Chronic Back Pain	___Vaginal Infections
___Hernia	___Parkinson's Disease	___Gout	___Herpes
___Hiatal Hernia	___Dementia	___Glaucoma	___HPV
___Barrett's Esophagus	___Migraine Headaches	___Cataracts	___Condyloma
___H Pylori	___Insomnia	___Retinal Problems	___Venereal Disease
___Fecal Incontinence	___Sleep Apnea	___Skin Rashes	___Gonorrhea
___Pancreatitis	___Asthma	___Skin Cancer	___Chlamydia
___Colon Cancer	___COPD	___Bronchitis	___Tuberculosis
___Colon Polyps	___Emphysema	___Tonsilitis	___Typhoid fever
___Breast Lump	___Pneumonia	___Mononucleosis	___Rheumatic Fever
___Breast Cancer	___Sinus/Nasal Allergies	___Measles	___Scarlet Fever
___Prostate Cancer	___TMJ	___Mumps	___Miscarriage

Cancer, any other type:_____

OTHER (list any other health conditions):_____

Patient Name_____ DOB_____ Today's Date_____

SURGICAL HISTORY (Please **CIRCLE or CHECK** Past Procedures)

___No Surgical Procedures	___Cardiac Catheter	___Colon Resection	___Vasectomy
___Gallbladder	___Heart Stent	___Obesity/Weight Loss	___C-Section
___Hernia Repair	___Heart Bypass	___Stomach	___Hysterectomy
___Hemmerrhoid	___Defibrallator	___Thyroid	___Breast Surgery
___Appendectomy	___Pacemaker	___Tonsillectomy	___Mastectomy
___Kidney	___Heart Valve Replacement	___Organ Transplant	___Prostat Surgery
___Joint Replacement	___Liver Biopsy	___Tummy Tuck	___Tubal Ligation

Other Surgeries:_____

FAMILY MEDICAL HISTORY

Has any member of your family ever had:

___No Known Family History Colon Polyps: ___Y___N Colon Cancer: ___Y___N

Prostate Cancer: ___Y___N Gynecological Cancer: ___Y___N Other Cancers?: ___Y___N

MOTHER: __Diabetes __HTN __Heart Disease/CAD __Colon Polyps __Colon Cancer __Other Cancers:_____

FATHER: __Diabetes __HTN __Heart Disease/CAD __Colon Polyps __Colon Cancer __Other Cancers:_____

SISTER: __Diabetes __HTN __Heart Disease/CAD __Colon Polyps __Colon Cancer __Other Cancers:_____

BROTHER: __Diabetes __HTN __Heart Disease/CAD __Colon Polyps __Colon Cancer __Other Cancers:_____

SOCIAL HISTORY:

Marital Status: ___Single ___Married ___Widowed ___Seperated ___Divorced ___Same Sex-Partner

Children: ___*No* ___*Yes How many children?*___ **I currently live:** ___*Alone* ___*With Others* ___*Nursing Home*

Employment: ___*Employed* ___*Unemployed* ___*Retired* ___*Disabled* **Occupation:_____**

Alcohol History:	**Tobacco History:**	**Recreational Drug History:**
__Never	**__I have never smoked/chewed**	**__I have never used recreational drugs**
__Less than 7 drinks per week	**__I smoke less than 1 pack a day**	**__I am currently using recreational drugs**
__More than & drinks per week	**__I smoke more than 1 pack a day**	**__I have used recreational drugs in the past**
__I quit using alcohol	**__I quit smoking/chewing**	**__I have been treated for substance abuse**