The Ultimate Care

Carolina Colorectal Surgery, PC

2501 Atrium Drive, Suite 305 Raleigh, NC 27607 Sankar N. Adusumilli MD, MS, FACS, FASCRS Phone: (919) 235-0216 Fax: (919) 235-0217

Patient Information

Name: _____ Today's Date:_____ _____
(Last) (First) (M.I)

Sex (Circle one): **M** **F** Marital Status (Circle one): **Single** **Married** **Divorced** **Widow** **Legally Separated**

Date of Birth:_____ Age:_____ **Phone # (BEST Daytime):**_____

Social Security # **(Required)**:_____ _____ Phone# : _____Home

Phone # :_____ Cell

Email:_____ Phone #:_____ Work

Address: _____

City:_____ State: _____ Zip:_____

Emergency Contact Person :_____
(Name) (Relationship) (Phone) Please be sure this is not your own phone number

Whom may we thank for referring you? _____

Referring Physican: (Full name)_____Phone #_____

(Practice Name and Address/City)_____Fax #_____

Primary Care Physician: (Full Name)_____ Phone #:_____

(Practice Name and Address/City)_____ Fax #_____

Cardiologist Physician: (Full Name)_____ Phone #:_____

(Practice Name and Address/City)_____ Fax #_____

Employment Information

Patient Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Insurance Information

PRIMARY INSURANCE: _____ ID #:_____

Group #:_____ Mailing Address For Claims:_____

SECONDARY INSURANCE: _____ ID #:_____

Group #:_____ Mailing Address For Claims:_____

TERTIARY INSRUANCE: _____ ID #:_____

Group #:_____ Mailing Address for Claims:_____

Primary Insured Subscriber:_____**Primary Subscriber's DOB**: ____/____/_____

Mailing Address: (If different from Above):_____

Patient's Relationship to Primary Insured: Self____ Spouse_____Child_____Other: _____

Medications

Patient Name: _____ ***Date of Birth:*** _____

Allergies to Medications List all medications, both prescrition and non-prescription that you are allergic to:	
Medication Name	***Type of allergic reaction: Such as rash or breathing difficulty***
__No Known Allegries	

Are You Allergic To LATEX? (Please Circle): **YES or NO**

Medication List List ALL Rx or prescription and non-prescription (Over-the counter) meds that you are currently taking: Be sure to Include Reason for Taking and all other details for each medication.			
Medication Name	***Reason for Taking*** ***(such as Blood Pressure, Reflux, etc)***	***Dose*** ***(such as 10 mg, 1 tsp, 30mL)***	***How Often?*** ***(such as 3x/day, as needed)***
__No Current Medications			

Pharmacy Name: _____**Phone Number:** _____

Intersecting Streets: _____**City/State:** _____

Pateint Name_____ DOB_____

Today's Date:_____

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

___No Past Medical Histoy	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
Irritiable Bowel Syndrome	A-FIB/Atrial Fibrilation	Anemia	History of Suicide Attempt
Diverticula Disease	Irregular Heartbeat	Thyroid Disease	Alcholism
Ulcerative Colitis	Heart Murmurs	Goiter/Enlarged Thyroid	Chemical Dependency
Peptic Ulcer	Congestive Heart Failure	Diabetes	Liver Disease
GI Bleeding	Stroke/TIA	Bleeding Disorders	Liver Cancer
Hemorrhoids	Seizures	AIDS HIV Positive	Cirrhosis
Appendicitis	Neurological Disorders	Arthritis/Osteoartritis	Fatty Liver
Gallstones	Multiple Sclerosis	Rheumatoid Arthritis	Hepatitis
Celiac Disease	Epilepsy	Chronic Back Pain	Vaginal Infections
Hernia	Parkinson 's Disease	Gout	Herpes
Hiatal Hernia	Demensia	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	Tonsillitis	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): _____

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
__Hemorrhoid	__Defibillator	__Thyroid	__Breast Surgery
__Appendectomy	__Pacemaker	__Tonsillectomy	__Mastectomy
__Kidney	__Heart Valve Replacement	__Organ Transplant	__Prostate Surgery
__Joint Replacement	__Liver Biopsy	__Tummy Tuck	__Tubal Ligation

Other Surgeries:_____

FAMILY MEDICAL HISTORY **__ No Known Family History**

Has any member of your family ever had: **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:_____

Other Family Medical History: _____ _____

SOCIAL HISTORY:

Marital Status: **__Single __Married __Widowed __Separated __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 7 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**

Pateint 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 Urniation
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

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
Pain, weakness, numbness in:
Neck/Shoulders
Arms
Back
Feet/Legs
Hands
Hips

MEN Only
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis

WOMEN Only
Nipple discharge
Abnormal Pap Smear
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot flashes
Painful intercourse
Vaginal Discharge

Please list any other symptoms you have:

_____
_____
_____
_____
_____

CAROLINA COLORECTAL SURGERY

AUTHORIZATION FOR HEALTH CARE, REMINDERS OF APPOINTMENTS AND PERMISSION TO SAY YOUR NAME

Carolina Colorectal Surgery, PC and staff members of the practice may need to use your name address and phone number to contact you with appointment reminders and health related information to your interest.

- We will call you by name when it is time for your appointment.
- We may call your name out loud to receive information while you are in the waiting room.
- We may leave a message on your answering machine in the case of your absence. Such information may be subject to re-disclosure and they may no longer be protected by the privacy policies.

You may restrict individuals or organizations to whom your health information is released or you may revoke your authorization at any time. The request for revocation will have to be given to us in writing. Any information released prior to receiving the request for revocation cannot be contested. In addition, if you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse authorization, your refusal will not affect the treatment we provide or the methods used to obtain reimbursement for your care.

SELECT & SIGN ONLY ONE (YES OR NO) of the following:

- **YES**, I _____ have carefully read the above and hereby **DO authorize** Carolina Colorectal Surgery, PC to say my name and for disclosure of health as described above.

- **NO**, I_____ have carefully read the above and hereby **DO NOT authorize** Carolina Colorectal Surgery, PC to say my name and for disclosure of health as described above.

I authorize Carolina Colorectal Surgery, P.C. to release any and all medical information to the following people:

Name: _____Relationship: _____Phone#_____

Name: _____Relationship: _____Phone#_____

Name: _____Relationship: _____Phone#_____

Name: _____Relationship: _____Phone#_____

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

_____ _____

Patients Signature (Parent if minor) Date

CAROLINA COLORECTAL SURGERY

MEDICAL SERVICE COVERAGE AND PAYMENT AGREEMENT

I _____ hereby authorize **Carolina Colorectal Surgery** to perform medical and laboratory services.

I also agree that all my insurance benefits are hereby assigned to **Carolina Colorectal Surgery, PC**. Any portion of the bill unpaid is my responsibility.

I understand the following:

- All co-pays, deductibles, outstanding balance and out of network payments are to be paid at the time of check-in.
- Any fees or costs not paid at the time of service are due within 14 days of receipt of bill.
- Any bill unpaid after 30 days will be subject to bear interest at the highest rate authorized by law in the state of North Carolina.
- All returned checks will be charged a fee of $25.00
- Any services not covered by the insurance company are my responsibility.
- It is my responsibility to check with my insurnace company to determine my coverage or responsibility for any service.
- Carolina Colorectal Surgery and staff are not responsible for determining your specific insurance benefits before or after a procedure.
- Prescriptions and refills take up to 72 hours to process.
- Prescription Refills should be initiated by me by requesting that my pharmacy FAX a refill authorization Request to Carolina Colorectal Surgery to 919-235-0217.
- Doctors may return calls up to 24 hours.
- I will be charged a $25.00 fee for Missed Appointments when a minimum of 24 hour advance notice is not given.

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

_____ _____

Patients Signature (Parent if minor) Date