CENTER FOR COLON & RECTAL HEALTH, INC.

Langhorne 215-741-4910 Doylestown 215-348-7600

REGISTRATION SHEET

PLEASE PRINT

NAME

SINGLE MARRIED WIDOWED DIVORCED

ADDRESS SOCIAL SECURITY #

CITY STATE ZIP

HOME PHONE CELL PHONE DATE OF BIRTH SEX

LANGUAGE RACE ETHNICITY

E-MAIL ADDRESS

OCCUPATION BUSINESS PHONE

EMPLOYED BY ADDRESS

NAME OF SPOUSE OR PARENT

SPOUSE'S DATE OF BIRTH SPOUSE'S SOCIAL SECURITY #

SPOUSE'S EMPLOYER BUSINESS PHONE

EMERGENCY CONTACT PHONE

FAMILY PHYSICIAN REFERRED BY

HOW DID YOU HEAR ABOUT OUR PRACTICE? PLEASE CHECK BELOW:

ADVERTISING PRIMARY PHYSICIAN SPECIALIST PHYSICIAN HOSPITAL
PATIENT IN PRACTICE WORD OF MOUTH INSURANCE COMPANY INTERNET

PHARMACY PHONE

MEDICAL INSURANCE

IDENTIFICATION # GROUP #

PATIENT'S RELATIONSHIP TO POLICYHOLDER:
SELF SPOUSE DEPENDENT OTHER

SECONDARY INSURANCE

SECONDARY IDENTIFICATION # SECONDARY GROUP #

SIGNATURE DATE

CENTER FOR COLON & RECTAL HEALTH, INC.

Langhorne
215-741-4910

Doylestown
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PATIENT CONSENT

Name (Please print) _____

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1. I give my permission to Center for Colon & Rectal Health, Inc. to access my medication history.

_____ Yes _____ No

2. I would like to read or be given a copy of the HIPAA Notice of Privacy Practices for Center for Colon & Rectal Health, Inc.

_____ Yes _____ No

3. I request that payment of authorized Medicare and/or Insurer benefits be made on my behalf to Center for Colon & Rectal Health, Inc. or their associates for services furnished to me by said physicians. I authorize Center for Colon & Rectal Health, Inc. to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under Medicare guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the third payor. I understand that laboratory, pathology, x-ray, or anesthesia services may be provided by outside sources. I agree that payment for these services will be arranged directly by my insurance carrier or myself.

_____ Yes _____ No

4. You may leave messages on my home phone # _____ _____ Yes _____ No

You may leave messages on my cell phone # _____ _____ Yes _____ No

5. The following may receive my Protected Health Information on my behalf:

_____ Yes _____ No Spouse Name/Phone # _____

_____ Yes _____ No Children Name/Phone # _____

_____ Yes _____ No Other Name/Phone # _____

_____ _____

Patient Signature Date

NAME _____ DATE OF BIRTH _____ DATE _____

PAST MEDICAL HISTORY (Check Here if **NO** to All _____)

Anxiety Disorder	Y / N	Hypertension	Y / N
Asthma	Y / N	Kidney Disease	Y / N
COPD	Y / N	Liver Disease	Y / N
Cancer GI	Y / N	Pulmonary Embolism	Y / N
Coronary Artery Disease	Y / N	Radiation	Y / N
Depression	Y / N	Sleep Apnea	Y / N
Diabetes	Y / N	Stroke	Y / N
Diverticulitis	Y / N	TIA	Y / N
Fibromyalgia	Y / N	Thyroid Disease	Y / N
GERD/Reflux	Y / N	Valvular Heart Disease	Y / N
HPV Vaccine	Y / N	Other _____	
High Cholesterol	Y / N	_____	

SOCIAL HISTORY

Advance Directive	Y / N				
Alcohol Intake	None _____	Occasional _____	Moderate _____	Heavy _____	
Alcohol Years of Use	_____ year(s)				
Smoking Status	Former _____	Current _____			
How Much	1 PPW _____	2 PPW _____	¼ PPD _____	½ PPD _____	
	1 PPD _____	1½ PPD _____	2 PPD _____	3+PPD _____	
Years of Smoking	_____ year(s)	At what age did you begin smoking? _____			
Illicit Drugs	Y / N				

FAMILY HISTORY

Mother - Alive Y / N Cause if deceased _____

Father - Alive Y / N Cause if deceased _____

Does anyone or has anyone in your family had:

Colon Cancer	Y / N	Relation to you _____
Colon Polyps	Y / N	Relation to you _____
Colitis	Y / N	Relation to you _____
Crohn's Disease	Y / N	Relation to you _____
Family History of Cancer	Y / N	Relation to you _____
Other _____		Relation to you _____

YOUR PHYSICIANS (Who should receive a report/letter)

Primary Care _____

GI (If you have a doctor) _____

Hematology/Oncology _____

Gynecology _____

Urology/Gynecology _____

Any Other Physician _____

CENTER FOR COLON & RECTAL HEALTH, INC. +

BRING OR HAVE FAXED ALL RECORDS, X-RAYS, CT-SCANS AND LABWORK FROM OTHER PHYSICIANS PERTAINING TO YOUR VISIT WITH US. IF INSTRUCTED, USE A SALINE FLEET ENEMA 1 TO 2 HOURS PRIOR TO YOUR APPOINTMENT. BRING INSURANCE CARDS AND PHOTO ID.

Health History Questionnaire

NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

SURGICAL HISTORY (Including Colonoscopy)

Procedure	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS (Including Vitamins, Herbals and Supplements)

Medication	Reason Taken
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

VACCINATIONS (Including Flu and Pneumonia)

Vaccine Type	Date
_____	_____
_____	_____
_____	_____

ALLERGIES/ADVERSE REACTIONS

Check Here if No Known Drug Allergies _____

Drug/Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

SEXUALLY TRANSMITTED DISEASES Y / N If Yes, Please Explain

_____

_____

NAME _____ DATE OF BIRTH _____ DATE _____

GYN HISTORY

Sexually Active Y / N

Birth Weight of Children _____

C-Section Y / N How many _____

Episiotomy Y / N How many _____

Forceps Delivery Y / N How many _____

Hysterectomy Y / N If Y, was it Vaginal Y / N Total _____ Partial _____

Painful Intercourse Y / N

Tear at Birth Y / N How many _____

Vaginal Births Y / N How many _____

Abnormal Pap Y / N

HPV Vaccine Y / N

Date of Most Recent Mammogram _____

Date of Most Recent Bone Density _____

Your Age at First Childbirth _____

Date of Last Pap Smear _____

Hormone Replacement Therapy Y / N

If Post Menopausal, Age at Menopause _____

STIs/STDs

Abnormal Pap Y / N If Yes, Please Explain

_____

_____

_____

NAME _____ DATE OF BIRTH _____ DATE _____

Being seen by Dr. _____ at Center for Colon & Rectal Health, Inc.

BOWEL CONTROL SATISFACTION SURVEY

____ N/A (Please read survey and check if not applicable)

Which symptoms best describe you:
____ Bowel accidents because I am unable to make it to the bathroom in time
____ Bowel accidents while asleep/unaware
____ Frequent loose, watery stools
____ No accidents - I always stay near a bathroom to prevent them
____ I am afraid to go out because I might have an accident

How long have you had these symptoms **_____**

Approximately how many bowel accidents do you have per week **_____**

Behavior Modifications tried **_____**
(i.e. diet changes, fiber, lifestyle changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help your symptoms? Y / N
If Yes, check the medications you have tried:
____ Diphenoxylate ____ Lomotil®
____ Imodium® ____ Loperamide
____ Imotil® ____ Other _____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief *Completely Cured*

If you have stopped taking your medications, explain why:
____ Did not help ____ Side effects ____ Too expensive
Describe side effects _____

What is the level of frustration with your bowel control symptoms. Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated *Very Frustrated*

I am interested in learning more about other treatment options Y / N