

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 _____

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PATIENT CONSENT

Name (Please print) _____

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 _____

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
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Not Frustrated

Very Frustrated

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