COLON AND RECTAL ASSOCIATES, LTD.

1235 Old York Road, Suite G 20 * Abington, PA 19001 * Tel: 215-517-1250 * FAX 215-517-0821
Joseph H. Nejman, M.D.
Steven G. Harper, M.D.
D. Mark Zebley, M.D.
Steven A. Fassler, M.D.
Soo Y. Kim, M.D.

Please bring the following items with you to your appointment:

- 4 page information sheet **filled out completely** making sure you list of all of your medications both prescription and over the counter including dosages and directions. (We update this information quite frequently. Please complete these pages even if you have been seen by our doctors in the past)

1. Signed Patient Privacy Notice/Release of Medical and Billing Information
2. Photo ID (ie: Driver's License)
3. Insurance Cards (you will need to show them at every appointment)
4. Copayment (typically listed on your insurance card for specialist, **copay is due the day of your appointment**) we accept cash, check, Visa, MasterCard and Discover for your convenience.

If your insurance requires a referral please be sure to request one at least 72 hours prior to your appointment date.

We have two office locations, please refer to the enclosed appointment card for the address where you have been scheduled, and report to that address.
Please arrive 15 minutes prior to your appointment time to allow time for check- in.

You must bring cash to exit the parking garage. Our office does not stamp parking tickets and we cannot offer any parking discounts.

Thank you for your cooperation.

Revised 8/16

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COLON AND RECTAL SURGERY
PROCTOLOGY

PATIENT INFORMATION

NAME: _____ REFERRING DOCTOR:_____

ADDRESS: _____ FAMILY DOCTOR: _____

CITY/STATE/ZIP CODE: _____ CARDIOLOGIST: _____

HOME PHONE: _____WORK PHONE: _____CELL PHONE: _____

E-MAIL ADDRESS: _____SOCIAL SECURITY #: _____

AGE: _____DATE OF BIRTH: _____ GENDER: MALE☐ FEMALE☐

MARITAL STATUS: MARRIED☐;DIVORCED☐;SINGLE☐;WIDOWED☐;PARTNER☐

SPOUSE'S NAME: _____SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S SOCIAL SECURITY #: _____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE#:_____

RACE: ASIAN☐ HAWAIIAN/PACIFIC ISLANDER☐ BLACK/AFRICAN AMERICAN☐
WHITE☐ HISPANIC☐ OTHER☐ REFUSED☐

ETHNICITY: HISPANIC OR LATINO☐ NON-HISPANIC☐ REFUSED☐

LANGUAGE: ENGLISH☐ OTHER☐ (SPECIFY:_____)

OCCUPATION: _____

PATIENT'S EMPLOYER: _____EMPLOYER'S ADDRESS: _____

PRIMARY INSURANCE CO. AND ADDRESS: _____

_____

SUBSCRIBER'S NAME:_____ID#:_____GRP#:_____

SECONDARY INSURANCE CO. AND ADDRESS: _____

_____

SUBSCRIBER'S NAME:_____ID#:_____GRP#:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other private insurance, and any other health plan to **COLON AND RECTAL ASSOCIATES, LTD.**
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED_____DATE_____

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE PAGE 2

Name: _____ **Height:** _____

Date: _____ **Weight:** _____

State nature of complaint, symptoms and duration: _____

_____

If you have had bleeding, circle the appropriate description(s):
Blood has been: Bright red – Mixed with the stool – On surface of stool – On the toilet tissue – In the toilet bowl – On underclothes

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

☐ Yes ☐ No Colon or rectal cancer. If yes, age diagnosed _____
☐ Yes ☐ No Colon or rectal polyps. If yes, age diagnosed _____
☐ Yes ☐ No Personal history of any other type of cancer. Age of diagnosis _____
What type? _____
☐ Yes ☐ No Inflammatory bowel disease (Crohn's disease or ulcerative colitis)
☐ Yes ☐ No Diverticulitis
☐ Yes ☐ No Diverticulosis
☐ Yes ☐ No Previous colon or rectal surgery
☐ Yes ☐ No Previous abdominal surgery
☐ Yes ☐ No Previous anal surgery
☐ Yes ☐ No Rectal bleeding
☐ Yes ☐ No Constipation, diarrhea or change in bowel habits
☐ Yes ☐ No Fecal Incontinence
☐ Yes ☐ No Recent fevers
☐ Yes ☐ No Weight loss
☐ Yes ☐ No Previous organ transplant
☐ Yes ☐ No Blood Disorder(s), e.g. Von Willebrand's Disease
☐ Yes ☐ No Iritis (inflammation of the eyes)
☐ Yes ☐ No Blindness
☐ Yes ☐ No Ulcers in the mouth
☐ Yes ☐ No Defibrillator
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Chest pain or angina
☐ Yes ☐ No Myocardial infarction (heart attack)
☐ Yes ☐ No Palpitations or Arrhythmias
☐ Yes ☐ No Previous heart surgery
☐ Yes ☐ No Hypertension (high blood pressure)
☐ Yes ☐ No Stroke
☐ Yes ☐ No Claudication (Poor Blood flow to the legs)
☐ Yes ☐ No Blood clot in the legs
☐ Yes ☐ No Blood clot in the lungs (pulmonary embolism)
☐ Yes ☐ No Asthma or Emphysema
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Sleep Apnea. If yes, require CPAP? ☐ Yes ☐ No
☐ Yes ☐ No Kidney failure/dialysis
☐ Yes ☐ No Urinary or prostate problems/Prostate cancer
☐ Yes ☐ No Radiation treatments for cancer
☐ Yes ☐ No Impotence
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Have you taken steroids (Prednisone, etc.) in last 30 days
☐ Yes ☐ No Arthritis

NAME _____ **DOB** _____

☐ Yes ☐ No Neurologic illness
☐ Yes ☐ No Psychiatric illness

☐ Yes ☐ No Previous blood transfusion
☐ Yes ☐ No Easy bleeding or bruising
☐ Yes ☐ No Anemia
☐ Yes ☐ No HIV Positive
☐ Yes ☐ No Have you taken aspirin or non-steroidal anti-inflammatory drugs (Ibuprofen, etc.) within the last 7 days?
☐ Yes ☐ No Gallbladder disease or gallstones
☐ Yes ☐ No Liver disease or cirrhosis
☐ Yes ☐ No Ulcer of the stomach or duodenum (small intestine)
☐ Yes ☐ No Gastritis (inflammation of the stomach)
☐ Yes ☐ No Diseases of the Pancreas

Are there any other medical problems that we should be aware of:_____

_____

☐ Yes ☐ No Do you smoke cigarettes currently? Packs/day: _____
☐ Yes ☐ No Have you ever smoked? Year you quit smoking:_____
☐ Yes ☐ No Do you drink alcohol? Drinks/week: _____
☐ Yes ☐ No Have you ever been treated for alcoholism?
☐ Yes ☐ No Have you ever used intravenous drugs?
☐ Yes ☐ No Have you ever had a Cat Scan? Date: _____
☐ Yes ☐ No Have you ever had a Barium Enema? Date: _____
☐ Yes ☐ No Have you ever had a Colonoscopy? Date: _____
☐ Yes ☐ No Have you ever had a Flexible Sigmoidoscopy? Date: _____

☐ Yes ☐ No Are you currently employed?
Occupation: _____
☐ Yes ☐ No Are you married?
☐ Yes ☐ No Do you have children?
Vaginal Deliveries ☐ Yes ☐ No
Episiotomies ☐ Yes ☐ No

Past Surgeries:
Please list your previous surgeries:_____

_____

FAMILY HISTORY
Do you have a <u>first-degree relative</u>, <u>who before the age of 50</u>, was diagnosed with Cancer?

☐ Yes ☐ No If yes, who?_____
What type? _____
Age at diagnosis _____

Do you have 3 or more relatives with Colon or Rectal Cancer? Yes☐ No☐

<u>Has</u> anyone else in your family had the following:
☐ Yes ☐ No **Colon or Rectal Cancer** (Please circle)
If yes, who?_____
☐ Yes ☐ No **Other Cancer**
If yes, who?_____
What type? _____
☐ Yes ☐ No **Colon or Rectal Polyps**
If yes, who?_____
☐ Yes ☐ No **Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)**

PATIENT'S NAME _____ DOB _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE#: _____

MEDICATIONS:

☐ I am **not** currently taking any prescription or over the counter medications.

☐ I currently take the following medications:

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS, VITAMINS, AND SUPPLEMENTS.

NAME OF DRUG	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

☐ Yes ☐ No Do you have any drug allergies?

If yes, please name the drugs to which you are allergic:

_____

_____

_____

_____

PATIENT SIGNATURE _____

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A. PATIENT PRIVACY NOTICE

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

(You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at www.colonandrectalassoc.com)

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ Date_____

B. RELEASE OF MEDICAL and BILLING INFORMATION

I, _____, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name:_____ Relationship:_____

I, _____, do not authorize anyone to have access to my billing and medical information.

I understand that by signing this release, the designated person(s) above will be able to speak to any member of Colon and Rectal Associates' staff. Furthermore, I understand the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointments.

Patient's/Guardian's Printed Name: _____

Patient's/Guardian's Signature: _____ Date:_____

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes No

I give consent for the office to leave results of testing on my answering machine, by text, voicemail or with a spouse, parent or other household member. Yes No