

BAY AREA COLON & RECTAL SURGEONS

PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you properly, we will need the following information. Please print. All information is strictly confidential.

PATIENT INFORMATION

PATIENT NAME: _____ HOME PHONE _____
HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____
ALTERNATE CELL/PAGER NUMBER/E-MAIL _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX _____
MARITAL STATUS _____ ETHNICITY _____ DRIVER'S LICENSE _____
EMPLOYER _____ OCCUPATION _____
WORK PHONE _____ EXT _____ PRIMARY CARE PHYSICIAN _____
HOW DO YOU PREFER TO BE ADDRESSED? _____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY _____ RELATIONSHIP _____
ADDRESS _____ DATE OF BIRTH _____
EMPLOYER _____ WORK PHONE _____ EXT _____

INSURANCE INFORMATION

PLEASE COMPLETE AND GIVE OFFICE COPIES OF YOUR CARDS.

PRIMARY INSURER _____ ID# _____ GROUP# _____
PLEASE CIRCLE: HMO PPO PRIVATE JOHN MUIR HEALTH NETWORK HILL PHYSICIANS EAST COUNTY MEDICAL GP
POLICY HOLDER _____ DOB _____ RELATIONSHIP _____
SECONDARY INSURER _____ ID# _____ GROUP# _____
PLEASE CIRCLE: HMO PPO PRIVATE JOHN MUIR HEALTH NETWORK HILL PHYSICIANS EAST COUNTY MEDICAL GP
POLICY HOLDER _____ DOB _____ RELATIONSHIP _____

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY _____
RELATIONSHIP _____ HOME PHONE _____ WORK PHONE _____

PAYMENT FOR SERVICES

I understand that it is my responsibility to verify with my insurance carrier if my physician is a participating provider. I realize that I am financially responsible for all medical services rendered to me and or my dependents regardless of the decision involving reimbursement by my insurance carrier. I authorize my physician's to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company. I hereby assign my insurance benefits to be paid directly to my physician.

Patient Signature _____ Date _____

PAST MEDICAL HISTORY					
Please check whether you have or have had any of the following conditions:					
Acute myocardial infarct (heart attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coronary artery disease/heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Atrial fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure/Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COPD/emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Internal defibrillator (AICD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type _____			Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type _____			Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Taking Coumadin/Plavix/Aggrenox	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Others:					

PAST SURGICAL HISTORY			
Please list all prior surgeries:			
Surgery	Year	Surgery	Year

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
SisterS	Please list any significant medical problems (if any):		
BrotherS	Please list any significant medical problems (if any):		
Family history of	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Family History of: <input type="checkbox"/> Colon Cancer _____ <input type="checkbox"/> Colon Polyp _____ <input type="checkbox"/> Crohn's Disease _____ <input type="checkbox"/> Ulcerative Colitis _____ <input type="checkbox"/> Other Gastrointestinal Cancers: _____ _____			
Previous Colonoscopies: Year _____ by Dr. _____ Diagnosis _____			
Previous Endoscopies: Year _____ by Dr. _____ Diagnosis _____			

SEE ATTACHED ___

Reviewed by MD & discussed with patient _____

SOCIAL HISTORY

Drinks Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	Amount Consumed: <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> >5	
Tobacco Use	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever used intravenous drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? _____ How many sodas? _____	
Employment		
	Occupation (past or present): _____	
Miscellaneous	Have you ever received a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

<p>Constitutional</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>HEENT</p> <p>Frequent bleeding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent bleeding nose <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Neurologic/Psychiatric</p> <p>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Memory loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spinal cord injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Migraine headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Metabolic/Endocrine</p> <p>Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Too cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p> <p>Immunologic</p> <p>Hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Respiratory</p> <p>Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Musculoskeletal</p> <p>Joint pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Cardiovascular</p> <p>Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular pulse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart valve problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p>Vascular</p> <p>Pain in limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Varicose Veins <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p> <p>Dermatologic</p> <p>Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Abnormal pigmentation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>
<p>Hematologic</p> <p>Easy bruising or bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood clots in arms or legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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Anemia Other: _____	Genitourinary <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine Urinary burning sensation Night time urination Other: _____
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Gastrointestinal			
Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Regurgitation food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatic disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black colored stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
History peptic ulcer disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mucus in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bloating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fecal incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anal pain or itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallbladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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