



MEDICAL REGISTRATION AND HISTORY FORM

Name of Primary Care Physician (PCP) _____ PCP Phone # _____

Name of Referring Physician? _____ Phone # of Referring MD _____

Reason for your visit? bleeding colonoscopy constipation hemorrhoids itching pain - anal pain - abdominal warts
 other _____

PATIENT INFORMATION

Date _____

Social Security # (last 4 digits required) _____ - _____ - _____

Patient Name:

Last First Middle Initial

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married/Partnered Widowed Single Separated/Divorced

Spouse/Partner name _____

Birthdate _____

Patient Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

May we leave detailed messages? No Yes (at home on cell)

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____

INSURANCE

Who is responsible for this account _____

Relationship to Patient _____

Primary Insurance Co _____

Group # _____ ID # _____

Is patient covered by additional (secondary) insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Insurance Co _____

Group # _____ ID # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

 name of insurance company(ies)

and assign directly to ATL Colorectal Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 signature of beneficiary, guardian or personal representative date

 please print name of beneficiary, guardian or personal representative relationship to beneficiary

MEDICARE/MEDIGAP AUTHORIZATION ONLY NOT APPLICABLE

I request that payment of authorized Medicare benefits and , if applicable, Medigap benefits, be made either to me or on my behalf to

 name of doctor or clinic

for any services furnished to me by that provider.

To the extent permitted by law. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

 signature print name

FAMILY HISTORY	Age(s)	Alive Y/N	Cancer Y/N (specify)	Colon Polyps Y/N	Cause of Death
MOTHER					
FATHER					
SIBLINGS					
CHILDREN					

HEALTH HISTORY - Please check (✓) symptoms you currently have or have had in the past.

HEMATOLOGY:

- coumadin use
- aspirin use
- hypercoagulable state
- blood clots
- bleeding gums
- easy bleeding
- easy bruising
- swollen glands
- anemia
- varicose veins

CONSTITUTIONAL:

- chills
- fever
- weakness
- fatigue
- weight change
- loss of appetite
- cancer (location _____)

DERMATOLOGY:

- itching
- psoriasis
- rashes
- moles - requiring removal
- lumps
- eczema
- dry or sensitive skin
- hives
- keloid formation
- acne
- skin cancer

MUSCULOSKELETAL:

- back pain
- muscle aches
- osteoarthritis
- rheumatoid arthritis
- muscle weakness
- joint pain/swelling
- leg cramps
- sciatica
- osteopenia
- broken bones requiring surgery
- carpal tunnel syndrome

ENDOCRINOLOGY:

- thyroid disease
- diabetes
- polydypsia (excessive thirst)
- polyuria (excessive urination)
- weight loss
- sleep disturbance
- intolerance of heat or cold

NEUROLOGY:

- strokes
- migraines
- vertigo
- headache
- tingling/numbness
- seizures
- insomnia
- memory loss
- dizziness
- gait abnormality

OPHTHALMOLOGY:

- cataracts
- glaucoma
- nearsighted
- farsighted
- wear glasses
- wear contacts
- blurred vision
- diminished vision
- loss of vision

ENT/RESPIRATORY:

- shortness of breath
- pneumonia
- asthma
- emphysema
- tuberculosis exposure
- COPD
- hay fever
- cough
- bloody noses
- hearing loss
- change in voice
- sore throat
- ringing in ears
- sinus pain

CARDIOLOGY:

- chest pain
- hypercholesterolemia
- irregular heartbeat
- high blood pressure
- low blood pressure
- atrial fibrillation
- poor circulation
- edema
- varicose veins
- murmurs
- palpitations
- dizziness
- mitral valve prolapse
- heart attack
- aspirin use

GASTROENTEROLOGY:

- incontinence of stools
- peptic ulcer disease
- hiatal hernia
- incontinence of gas
- changes in stool size or texture
- bloating
- rectal bleeding
- anal fissure
- hemorrhoids
- excessive gas
- nausea
- heartburn or reflux
- vomiting
- difficulty swallowing
- irritable bowel syndrome
- abdominal pain
- diarrhea
- constipation
- change in bowel habits
- blood in stool
- colon polyps
- diverticulosis
- last colonoscopy date: _____

PSYCHOLOGY:

- depression
- tension/stress
- sleep disturbances.

- ADHD
- eating disorders
- mental or physical abuse
- anxiety

GENITOURINARY MALE:

- abnormal anal PAP smear
- erectile dysfunction
- benign prostatic hypertrophy
- prostate cancer
- history of radiation
- urinary incontinence
- kidney stones.
- hematuria (blood in the urine)
- difficulty urinating
- increased urinary frequency
- hernias
- kidney disease
- renal failure

GENITOURINARY FEMALE:

- dyspareunia (pain with intercourse)
- urinary incontinence
- # of vaginal childbirths _____
- episiotomies
- vaginal tears
- vacuum delivery
- fibroid uterus
- ovarian cyst
- endometriosis
- rectocele
- pneumaturia (air w/urination)
- hematuria (blood in urine)
- increased urinary frequency
- pelvic pain
- vaginal discharge
- abnormal PAP smear _____ date

INFECTIOUS DISEASE:

- chlamydia
- genital warts
- herpes
- HIV
- HPV (Human Papilloma Virus)
- syphilis
- gonorrhea

List prior surgeries & year performed _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

List allergies to medications or substances _____

Pharmacy Name _____ Phone (_____) _____

HEALTH HABITS

check (✓) which you use and how much:

Caffeine _____

Street Drugs _____

Tobacco _____

other _____

SIGNATURES

I have received both the ATL Colorectal Surgery P.C. Policy & Procedures statement and the Policy for Access & Denial of Patient Request for Protected Health Information. I have been provided an opportunity to review them. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or insurance status.

signature of beneficiary, guardian or personal representative

date

please print name of beneficiary, guardian or personal representative

relationship to beneficiary