

Colorectal Surgery Associates

Phone (816)941-0800 Fax (816)941-0080

Menorah Med. Center Campus Location
5701 W 119th St. Building C Suite 325
Overland Park, KS 66209

St. Joseph Health Center Location
1004 Carondelet, Suite 430
Kansas City, MO 64114

North Kansas City Hospital Location
2700 Clay Edwards Dr, Suite 230
North Kansas City, MO 64116

1. Please print, complete and sign these forms.
2. Bring them with you to your appointment.
3. Bring your insurance card(s).
4. Your co-pay will be collected upon check-in.
5. If you have FMLA or any other form that needs to be completed it must be given to the front desk. The \$20 fee to complete each form must be paid at the time you request to have the form completed.
6. Arrive 15 minutes before your scheduled appointment time for us to be able to process your paperwork before your appointment time.

Thank you and we look forward to meeting you!

Colorectal Surgery Associates

W. Edwin Conner, MD Pierre Castera, MD Lina O'Brien, MD Ben Mizrahi, MD

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(Please bring with you to your appointment)

Patient Name: _____	Today's Date: _____
Home address: Street: _____	
City: _____	State: _____ Zip: _____
Phone: _____	Cell Phone: _____ Work Phone: _____
Referring Physician: _____	Primary care physician: _____
Birth Date: _____	Age: _____ Sex: Male Female Transgender
Marital Status: (please circle) Single Married Partnership Divorced Widowed	
Social Sec #: _____	
Race: (please circle)	
American Indian Alaska Native Asian Native Hawaiian Black African American	
Hispanic White Other Race Other Pacific Islander Unreported/refused to Report	
Employment Status: _____	Employer: _____
Email Address: _____	

Emergency Contact: _____	Relationship: _____
Home Phone: _____	Work Phone: _____
FOR YOUR PRIVACY PLEASE NOTE THAT WE MAY CONTACT THIS PERSON IF WE CAN NOT CONTACT YOU	

Responsible Party (if other than patient/ minor): _____
Phone: _____ Address (if different): _____
Primary Insurance Name: _____
Policy #: _____ Group #: _____
Subscriber name: _____ DOB: _____ SS#: _____
Secondary Insurance Name: _____
Policy #: _____ Group #: _____
Subscriber name: _____ DOB: _____ SS#: _____

I certify that I have insurance coverage with the company (ies) listed in the previous section of this form. I assign directly to Colorectal Surgery Associates all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above named doctors may use my health care information and may disclose such information to my 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.

To insure the continuity of care, I also authorize Colorectal Surgery Associates to provide the information regarding my treatment and any medication I received at this office to my **primary care physician**.

Your first statement for a new balance due will be mailed to you free of charge. However, there will be a \$5 statement charge for each statement thereafter for all old balances

Signature: _____ **Date:** _____
(Patient *or* Parent/Legal guardian)

HIPAA NOTICES OF PRIVACY PRACTICES

Colorectal Surgery Associates is required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. A copy of Colorectal Surgery Associates Privacy Practices is available to you on CSAKC.com website or you can ask for a copy to be provided to you during your visit

I have reviewed Colorectal Surgery Associates' notice of privacy practices on their website or have been provided a copy during my visit.

Printed Patients name: _____ Date of Birth: _____

Signature: _____ Date: _____
(Patient or Patient representative)

Permission to Disclose Information

Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Colorectal Surgery Associates is required to obtain authorization from you in order to leave messages and/ or provide information regarding your care with any person(s) other than yourself.

RELEASE OF MEDICAL/APPOINTMENT INFORMATION:

I hereby allow the office to disclose health information to the following people:

Spouse Name: _____
 Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____

MESSAGES

I give my consent to the physicians and staff of Colorectal Surgery Associates to leave messages or discuss appointments/scheduling, treatment, surgery, lab, radiology results or other information regarding my care as follows:

On answering machine or voice mail on home phone?
____ YES: (If yes: ___ Brief / ___ Detailed message) _____ NO

On answering machine or voice mail on work phone?
____ YES: (If yes: ___ Brief / ___ Detailed message) _____ NO

On answering machine or voice mail on cell phone?
____ YES: (If yes: ___ Brief / ___ Detailed message) _____ NO

May we send emails to your provided email address?
____ YES: (If yes: ___ Brief / ___ Detailed message) _____ NO

Notes: _____

PATIENT INFORMATION

NAME: _____ AGE: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____

Family History-Please check all that apply to your family medical history.

Please indicate Maternal (M) or Paternal (P) relationship in space provided for Grandmother, Grandfather, Uncle and Aunt.

<input type="checkbox"/>	Colon Cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Colon polyps	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Gastric cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Pancreatic cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Breast Cancer	Mother	Sister	Grandmother	Aunt				
<input type="checkbox"/>	Ulcerative colitis	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Liver disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Diabetes	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Coronary artery disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt
<input type="checkbox"/>	Crohn's Disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Uncle	Aunt

Social History: (please circle)

Caffeine Use YES/NO If Yes, number of cups/drinks a day? _____
 Married YES/NO Single YES/NO Occupation: _____

Surgical History-Please check all that apply to your surgical past

<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	Heart Bypass
<input type="checkbox"/>	Gallbladder removal	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Tonsillectomy
<input type="checkbox"/>	Small Bowel Resection	<input type="checkbox"/>	Laparoscopy
<input type="checkbox"/>	Colon Resection	<input type="checkbox"/>	Prostate
<input type="checkbox"/>	Nissen Fundoplication	<input type="checkbox"/>	Bladder/cystocele/rectocele
<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	Cystocele/rectocele
<input type="checkbox"/>	Mastectomy	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Heart Valve replacement	<input type="checkbox"/>	Received Blood Transfusion
<input type="checkbox"/>	Stents		

List any other surgeries below:

Previous Colonoscopy: Yes No If Yes, when was it done? _____
 By Whom? _____ Polyps Found? YES NO Normal? YES NO

Medications: List all medications you presently take. Also please list any blood thinning medications (aspirin, Plavix, Coumadin, fish oil, Vit E, cardiotabs)

Allergies:	Drug/Agent	Reaction

NAME: _____ AGE: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____

Do you have or have you had within the past year:

Personal History Have you EVER had:

How many bed pillows do you use? _____
Do you wake up at night short of breath? Yes No
Appetite- Good ___ Fair ___ Poor ___
Belching or Heartburn? Yes No
Do you take laxatives: Yes No
Which ones: _____
Pain after eating: Yes No Where: _____
Stool leakage: Yes No
Leakage/seepage-poor control : Yes No
More frequent stools: Yes No
Urge to defecate: Yes No
Black stools: Yes No
Bright red stools: Yes No
Bleeding drips in water: Yes No
Bleeding on toilet tissue: Yes No
Anal burning-itching: Yes No
Anal pain after bowel movements: Yes No
Anal pain with b.m only: Yes No
Anal pain all the time: Yes No
Soreness or Bleeding of gums on brushing:
Yes No
Coughed up blood: Yes No
Difficulty swallowing: Yes No
Anemia: Yes No
Bone or joint disease: Yes No
Arthritis or Rheumatism: Yes No
Bladder Disease: Yes No
Cancer: Yes No
Ulcerative Colitis: Yes No
Crohns: Yes No
Irritable Bowel Disease: Yes NO
Diabetes: Yes No
Epilepsy: Yes No
Food, chemical or drug poisoning: Yes No
Gallbladder disease: Yes No
Asthma: Yes No
High or Low blood pressure: Yes No
Hives or eczema: Yes No
Jaundice or Liver Disease: Yes No
Migraine headaches: Yes No
Kidney Disease: Yes No
Nervous breakdown: Yes No
Neuritis/Neuralgia: Yes No
Pneumonia: Yes No
Polio or Meningitis: Yes No
Rheumatic fever or heart disease: Yes No
Tuberculosis: Yes No
HIV Positive: Yes No
Blood or plasma Transfusions: Yes No

Have you ever been advised to have any surgery which has not been done?: Yes No
If yes, please explain:

Have you been hospitalized for any illness: Yes No
Give details of hospitalization:

Current Weight: _____

Women Only-Menstrual History:

Do you take birth control pills: Yes No

Pains or cramps: Yes No

Regular yes no varies

Complications with pregnancy: Yes No

How many Cesarean Sections: _____

How many children born alive: _____

How many miscarriages: _____

Have you had a hysterectomy: Yes No

Are you pregnant: Yes No

Last Menstrual Period: _____

Patient Signature: _____

Date: _____

Physician's Review Signature: _____

Date: _____