

Colorectal Surgery Associates

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

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. Arrive 30 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

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

(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: M F
Marital Status: Single Married Divorced Widowed	
Social Sec #: _____	
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**.

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?	Please circle one:	YES	NO
On answering machine or voice mail on work phone?	Please circle one:	YES	NO
On answering machine or voice mail on cell phone?	Please circle one:	YES	NO
May we send emails to your provided email address?	Please circle one:	YES	NO

Notes: _____

PATIENT INFORMATION

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

Family History -Please check all that apply to your family medical history						Other relatives:
<input type="checkbox"/>	Colon Cancer	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Colon polyps	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Gastric cancer	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Pancreatic cancer	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Breast Cancer	Mother	Sister			
<input type="checkbox"/>	Ulcerative colitis	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Liver disease	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Diabetes	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Coronary artery disease	Mother	Father	Brother	Sister	
<input type="checkbox"/>	Crohn's Disease	Mother	Father	Brother	Sister	

Social History: (please circle)					
Marital status:	Single	Married	Divorced	Widowed	
Smoking/Tobacco Use:	Quit	No	Yes	Packs per day _____	Number of years _____
Alcohol Use :	Quit	No	Yes	If yes what type: beer	liquor wine How many drinks per day? _____
Caffeine Use	Number of cups/drinks a day? _____				
Occupation:	_____				

Surgical History -Please check all that apply to your surgical past		List any other surgeries below:
<input type="checkbox"/> Appendectomy <input type="checkbox"/> Gallbladder removal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Small Bowel Resection <input type="checkbox"/> Colon Resection <input type="checkbox"/> Nissen Fundoplication <input type="checkbox"/> Breast Lump/Mastectomy <input type="checkbox"/> Heart Valve replacement/stents	<input type="checkbox"/> Heart Bypass <input type="checkbox"/> Pacemaker <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Prostate <input type="checkbox"/> Bladder/cystocele/rectocele <input type="checkbox"/> Thyroid <input type="checkbox"/> Received Blood Transfusion	_____ _____ _____ _____ _____

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:

Fatigue: Yes No
Easy Bruising: Yes No
Joint Pains: Yes No
How many bed pillows do you use? _____
Do you wake up at night short of breath? Yes No
Shortness of Breath on:
Laying down? Yes No
One flight of stairs? Yes No
Walking several blocks? Yes No
Appetite- Good ___ Fair ___ Poor ___
Belching or Heartburn? Yes No
Do you take laxatives: Yes No
Which ones: _____
Nausea: Yes No
Vomiting: Yes No
Abdominal Pain: Yes No
Pain after eating: Yes No Where: _____
Loss of appetite, weight loss: Yes No
Stool leakage: Yes No
Change in size or shape of BM: Yes No
Change in bowel habits: Yes No
Constipation: 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
Chest pain: Yes No
Palpitations or fluttering of heart: Yes No
Soreness or Bleeding of gums on brushing: Yes No
Any skin rash: Yes No
Chronic or frequent cough: Yes No
Coughed up blood: Yes No
Difficulty swallowing: Yes No
Persistent hoarseness: Yes No
Recurrent head colds: Yes No
Recurrent nose bleeds: Yes No
Recurrent sore throats: Yes No
Sinus Trouble: 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
Have you been hospitalized for any illness: Yes No
Give details: _____

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: _____