

**Patient Information Form**  
**Please Print One Character In Each Space**

**Patient Name:** \_\_\_\_\_  
(First Name) (Initial) (Last Name) (Suffix: Jr., MD)

**Apt., Bldg., Unit, Etc.:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

**Emergency Contact Relationship:** \_\_\_\_\_

**Birth Date:** (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Sex:** M \_\_\_\_ or F \_\_\_\_ **Marital Status:** M\_, S\_, D\_, W \_\_\_\_  
(Single) (Divorced) (Widowed)

**Social Security Number:** \_\_\_\_\_ (Required , if you want us to file your insurance.)

**What is the name of the Doctor who referred you to us?** \_\_\_\_\_ **Ph. #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Suite, Bldg., Dept., Etc.:** \_\_\_\_\_ **Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Extension:** \_\_\_\_\_

**Primary Insurance**

**Effective Date:** (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Company Name:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_ **Ph.** \_\_\_\_\_

**Insured's Name (as it appears on the card)** \_\_\_\_\_

**Soc. Sec. Num.:** \_\_\_\_\_ **Birth Date:** (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Sex:** M \_\_\_\_ or F \_\_\_\_

**Please give your Insurance Card to the Receptionist so that we may make a copy for our records. If you have Supplementary Insurance, please allow us to copy those cards us well.**

*If the patient is minor, please complete the information on the reverse side of this form.*

I hereby authorize the release of any medical information, including HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for healthcare related utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to Georgia Colon & Rectal Surgical Associates, P.C. I hereby assign and authorize payment to Georgia Colon & Rectal Surgical Associates, P.C. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including, but not limited to: payment of those fees and charges not directly reimbursed to Georgia Colon & Rectal Surgical Associates, P.C. by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Georgia Colon & Rectal

SURGICAL ASSOCIATES, P.C.

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male / Female (circle)

Chief complaint \_\_\_\_\_  
(why are you here?)

## Your Symptoms

(check all that apply)

- Diarrhea  Constipation  Incontinence (loss of bowel control)  
 Abdominal pain  Bloating  Nausea/vomiting  
 Rectal bleeding  Swelling around the anus  Prolapse (tissue coming out of the anus)  
 Anal pain  Itching  Burning

## Past medical history (check all that apply)

- Heart disease  High blood pressure  Stroke  Heart attack \_\_\_\_\_ (year)  
 High cholesterol  Angina or chest pain  Heart murmur  Heart surgery  
 Implanted defibrillator or pacemaker  
 Lung disease  Asthma  Tobacco use \_\_\_\_\_ (packs per day)  
 Diabetes Type I \_\_\_\_\_ Type II \_\_\_\_\_  Low thyroid  
 Cancer If so, what kind? \_\_\_\_\_  
 Crohn's disease or  ulcerative colitis \_\_\_\_\_  
 Irritable bowel syndrome \_\_\_\_\_  Colon polyps \_\_\_\_\_

Medications: \_\_\_\_\_

Daily aspirin? Y/N On Plavix? Y/N On Coumadin? Y/N

Allergies to medications \_\_\_\_\_

## Past Surgical History (please give dates)

Colonoscopy \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

Colon surgery \_\_\_\_\_ Physician \_\_\_\_\_

Anal or rectal surgery \_\_\_\_\_ Physician \_\_\_\_\_

Artificial joints \_\_\_\_\_

Heart valves \_\_\_\_\_ On Coumadin? Y/N

Hysterectomy \_\_\_\_\_

Obstetric: \_\_\_\_\_ # pregnancies \_\_\_\_\_ # vaginal deliveries \_\_\_\_\_ # C-sections

History of episiotomy or tear \_\_\_\_\_

Other: \_\_\_\_\_

## Family History:

Relationship to you:

Age at diagnosis:

Breast cancer \_\_\_\_\_

Ovarian cancer \_\_\_\_\_

Uterine cancer \_\_\_\_\_

Thyroid cancer \_\_\_\_\_

Colon / Rectal cancer \_\_\_\_\_

Ulcerative colitis \_\_\_\_\_

Crohn's disease \_\_\_\_\_

Polyps \_\_\_\_\_

FAP \_\_\_\_\_

Other: \_\_\_\_\_

Medical conditions: Diabetes / High cholesterol / Heart disease / Lung disease

**New Patient Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my health care, Georgia Colon & Rectal Surgical Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information only be used or disclosed to carry out treatment, payment, or health care operations

I understand that Georgia Colon & Rectal Surgical Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Georgia Colon & Rectal Surgical Associates reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Georgia Colon & Rectal Surgical Associates change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on \_\_\_\_\_