

TO: Screening Colonoscopy Patient

FROM: Digestive Healthcare Associates, LLC
Liz Cruz, MD – 623-772-6999

RE: Screening Colonoscopy Packet

As promised, this is the screening colonoscopy packet you were told you would receive. In preparation for your colonoscopy please read all enclosed materials very carefully. This packet includes:

1. **Colonoscopy Brochure** – this explains the exam and the purpose of the exam. Please read it carefully and keep it for your records.
2. **Patient Registration and Intake Form** – please fill out these forms completely. This information will allow us to determine if we can schedule you directly for your procedure versus needing to be seen first in the office. **(PLEASE RETURN TO OUR OFFICE UPON COMPLETION)**
3. **Consent Form** – please read this form carefully. The consent form gives your physician permission to perform your colonoscopy. Only sign this form if you have read and thoroughly understand its contents. If you wish to be seen in the office prior to your procedure, please indicate that on your form. **(PLEASE RETURN TO OUR OFFICE UPON SIGNING)**

Once completed, **please mail the Patient Registration Form, Patient Intake Form and Consent Form to our office**. The sooner we receive these forms, the faster we can schedule your procedure. Our address is as follows:

Digestive Healthcare Associates
Attn: Screening Colonoscopy
9515 W. Camelback Road, Ste. 102
Phoenix, AZ 85037

If you have any questions regarding this packet or do not understand the instructions, please call our office at 623-772-6999. Thank you for your time; we look forward to serving you!

Patient Registration

PATIENT INFORMATION - the person being seen by the doctor

Last Name _____ First _____ Initial _____
 Home Address _____ Zip _____ City _____ State _____
 Mailing address _____ Zip _____ City _____ State _____
 Home Phone _____ Cell or Pager _____ Referring Doctor _____
 Patient's Relationship to Policyholder 1 – Spouse 2 – Child 3 – Other
 Date of Birth _____ Patient Sex _____ Male _____ Female
 Patient's Marital Status: (circle one) 1- Married 2-Single 5-Widowed 4-Other 6- Legally Separated 7-Divorced
 Patient's Social Security _____
 Patient's Employer _____ Occupation _____
 Address _____ Zip _____ City _____ State _____ Phone _____

GUARANTOR INFORMATION - the person who carries the insurance policy or is responsible for payment

Last Name _____ First _____ Initial _____
 Home Address _____ Zip _____ City _____ State _____
 Home Phone _____ Cell or Pager _____ Email Address _____
 Social Security _____ Date of Birth _____
 Mailing address _____ Zip _____ City _____ State _____
 Guarantor Employer _____ Occupation _____
 Address _____ Zip _____ City _____ State _____ Phone _____
 Primary Insurance _____ ID# _____ Group# _____
 Secondary Insurance _____ ID# _____ Group# _____
 Guarantor for Secondary? _____ Social Security _____
 Date of Birth _____ Mobile Phone _____

Emergency Contact- please provide a phone number other than your home

Name _____ Relationship _____ Phone # _____

Do you have an advanced directive for Healthcare (living will or medical Power of Attorney)?

If yes, we are required to have a copy on file. _____ Copy Received _____ Copy Requested

I authorize release of any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Digestive Healthcare Associates, LLC. I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the Insurance carrier. In the event that my account is assigned to a collection agency, I agree to pay an additional collection fee of 25% of the outstanding balance assigned to the collection agency. I also agree to pay any interest on the principal balance, court cost and attorney fees associated with the collection of my account. **In addition, I am aware that if I cannot attend a scheduled appointment I must call at least 24 hours in advance to avoid a \$20 no show fee.**

Patient Signature

Date

Staff Initials

Patient Intake Form

Name: _____ Age: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Who is your primary doctor? _____ Referring Physician? _____

Reason for seeing a Gastroenterologist: _____

Have you had a _____ Colonoscopy or _____ Sigmoidoscopy done in the past 10 years? Yes No
If yes, what year was it performed? _____ Anything found? _____

Have you had an Upper Endoscopy done in the past 10 years? Yes No
If yes, what year was it performed? _____ Anything found? _____

Has anyone in your immediate family been diagnosed with colon cancer or polyps? Yes No
If yes, please explain: _____

CURRENT SYMPTOMS: (check all that apply)

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Black, tarry stool	<input type="checkbox"/> Food sticking in esophagus
<input type="checkbox"/> Nausea	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Gas / bloating	<input type="checkbox"/> Painful swallowing
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Bloody vomiting	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Abnormal liver tests
<input type="checkbox"/> Fevers	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Belching/Burping	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chills	<input type="checkbox"/> Blood on toilet paper	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Stool incontinence
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Lactose intolerance	
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Anal pain	<input type="checkbox"/> Difficulty swallowing	

PAST MEDICAL/SURGICAL HISTORY (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Fatty liver
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Valley Fever	<input type="checkbox"/> GERD/Acid Reflux	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Heart Attack/MI	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Heart Disease/Stents	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Anemia
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Lung Clots	<input type="checkbox"/> Stomach / Duodenal Ulcer	<input type="checkbox"/> Depression
<input type="checkbox"/> Heart Valve Problem/Murmur	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Anxiety Disorder
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Helicobacter Pylori	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Irritable Bowel (IBS)	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Heart Arrhythmia	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Lupus	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Liver Cirrhosis
<input type="checkbox"/> Cancer, type(s): _____			

PAST SURGICAL HISTORY (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Tubaligation	<input type="checkbox"/> Stomach ulcer surgery	<input type="checkbox"/> Rectal prolapse surgery
<input type="checkbox"/> Removal of tonsils	<input type="checkbox"/> C-section	<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Coronary bypass
<input type="checkbox"/> Removal of gallbladder	<input type="checkbox"/> Prostate surgery	<input type="checkbox"/> Inguinal hernia repair	<input type="checkbox"/> Heart valve replacement
<input type="checkbox"/> Removal of appendix	<input type="checkbox"/> Thyroid surgery	<input type="checkbox"/> Abdominal hernia repair	<input type="checkbox"/> Pacemaker placement
<input type="checkbox"/> Hiatal hernia repair	<input type="checkbox"/> Lung surgery	<input type="checkbox"/> Total knee replacement	<input type="checkbox"/> Defibrillator (AICD) placement
<input type="checkbox"/> Removal of uterus	<input type="checkbox"/> Gastric bypass surgery	<input type="checkbox"/> Total hip replacement	
<input type="checkbox"/> Removal of ovary/ovaries	<input type="checkbox"/> Colon surgery	<input type="checkbox"/> Bladder suspension	

PLEASE LIST OTHER MEDICAL/SURGICAL HISTORY THAT MAY HAVE NOT BEEN LISTED:

Allergies to Medicine:

Are you allergic to any medication? Yes No

If yes, please name medications & reactions: _____

Medications:

Do you take aspirin or arthritis medication (ibuprofen, naproxen, Aleve, Motrin, Advil)? Yes No

If yes, please name medication & frequency: _____

Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)? Yes No

If yes, please name medication & frequency: _____

Please list other medications you are taking (include "over-the-counter" medicine and doses if possible)

Social History/Marital Status:

Single Married Divorced Separated Widowed

Your occupation: _____ Retired Unemployed Disabled

Do you / have you ever used tobacco? Yes No Packs per day? _____ Years? _____ Date Quit? _____

Do you use alcohol? Yes No Beer Wine Liquor How often? _____ How much? _____

Have you ever used street drugs? Yes No Type _____ Last use _____

FAMILY HISTORY

Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Stomach cancer	<input type="checkbox"/> Liver cancer	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Small bowel cancer	<input type="checkbox"/> Pancreatic cancer	<input type="checkbox"/> Celiac Disease
<input type="checkbox"/> Rectal cancer	<input type="checkbox"/> Esophageal cancer	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Uterine / Cervical cancer	<input type="checkbox"/> Skin cancer (ie. Melanoma)	<input type="checkbox"/> Other Cancer (please describe)	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

