Colon & Rectal Surgery Consultants: Patient Registration Forms Page 1/11

Thank you for choosing our office. The following patient registration forms are required and become part of your health care record. All information is confidential. Please complete the forms as accurately and completely as possible.

There are 6 forms to complete:

1. Demographic & Insurance information
2. Authorization to release Medical Records to our office
3. Authorization to discuss and release Medical Information with medical providers, family, or designated persons
4. Notice of Privacy Practices Acknowledgement
5. Chief Complaint/Patient Agenda for Your Visit/Family History/Social History
6. Medical History

Colon & Rectal Surgery Consultants: Patient Registration Forms Page 2/11
Demographic & Insurance Information

Patient Name:____ Date of Birth:__________
Last First Middle

Sex: _____M _____F Marital Status: ____Single ____Married ____Widowed ____Divorced ____Minor

Social Security Number:______________________ Phone:______________ Cell:____________

Address: _____________________ City:_____________ State:__________ Zip:___________

Patient Employer/School____________________________ Work Phone Number:___________

Name of Spouse:_________________________ Spouses Employer: _______________________

Person to Contact in case of emergency:________________ Phone #:____________________

Email Address: ____

PRIMARY INSURANCE INFORMATION

Name of Insured: ______________ Relationship to Patient:_________ Date of Birth:__________

Member#/SS#_________________ Employer: ______________ Phone:___________________

Business Address: _____________________ City: ____________ State: ______ Zip: ________

Insurance Company: _____________________ Group# ________________Union/local # ______

Claims Address: ________________________ City: _____________ State: _____ Zip: _______

Amount Deductible_______________ Office Visit Co-Pay: _________ Max Annual benefit? ______

SECONDARY/ADDITIONAL INSURANCE INFORMATION

Name of Insured: ______________ Relationship to Patient: _________ Date of Birth:__________

Member#/SS#_________________ Employer: ______________ Phone:___________________

Business Address: _____________________ City: ____________ State: ______ Zip: ________

Insurance Company: _____________________ Group# ________________Union/local # ______

Claims Address: ________________________ City: _____________ State: _____ Zip: _______

Amount Deductible_______________ Office Visit Co-Pay: _________ Max Annual benefit? ______

Colon & Rectal Surgery Consultants: Patient Registration Forms Page 3/11
Demographic & Insurance Information

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, has insurance coverage with ______________________________
Name of Insurance Company

and assign directly to Colon & Rectal Surgery Consultants, PC, Connie J. Pennington, MD/James Sheffey, MD, all insurance benefits of 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 physicians may use my healthcare information and may disclose such information to the above 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.

____ ______________________________

Signature of Patient or Guardian **Date**

Authorization to Release Medical Records to our Office

Colon & Rectal Surgery Consultants, PC
2306 Knob Creek Road, Suite 100
Johnson City, TN 37604
Phone: (423) 610-1177
Fax: (423) 610-1179

Connie J. Pennington, M.D.
James E. Sheffey, M.D.

To Whom It May Concern:

I, ____

Patient's Name

Hereby authorize the release of my medical records to:

Colon & Rectal Surgery Consultants, PC
Connie J. Pennington, M.D.
James E. Sheffey, M.D.
2306 Knob Creek Road, Suite 100
Johnson City, TN 37604
Phone: (423) 610-1177
Fax (423) 610-1179

____ ____________________
Signature of patient, or patient guardian Date

____ ____________________
Patient Social Security Number Date of Birth

____ ____________________
Signature of Witness Date

Colon & Rectal Surgery Consultants: Patient Registration Forms Page 5/11
Lifetime Authorization to Release Medical Records

Name of Patient: ____

Social Security #: _________________________________ Date of Birth: ___________________

I hereby authorize the office of Connie J. Pennington, M.D. / James E. Sheffey, M.D. or Colon & Rectal Surgery Consultants, P.C. to release, disclose, and deliver medical information to the **PHYSICIAN(S)** listed below, **IF REQUESTED BY PHYSICIAN**.

1. ____
2. ____
3. ____
4. ____
5. **ANY MEDICAL OFFICE OR FACILITY THAT ASKS: ____YES OR ____NO**

I hereby authorize the office of Connie J. Pennington, M.D. / James E. Sheffey, M.D. or Colon & Rectal Surgery Consultants, P.C. to release, disclose, and discuss any or all information regarding my office visit's, diagnosis and/or medical care to the following **INDIVIDUAL(S)**

1. ____
2. ____
3. ____
4. ____
5. **ANY FAMILY MEMBER OR FRIEND THAT ASKS ____YES ____NO**

I hereby authorize the office of Connie J. Pennington, M.D. and James E. Sheffey, M.D./Colon & Rectal Surgery Consultants, P.C. to leave messages on my answering machine or with anyone who answers my phone, if caller is identifying themselves from the our office. ______ **YES or _____NO**

PATIENT SIGNATURE: ________________________________ **DATE:** _____________________

NOTICE: I understand that I may revoke this authorization by sending a written notice to the office of Connie J Pennington, M.D. /James E. Sheffey, M.D./Colon & Rectal Surgery Consultants, P.C. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute breach of my rights to confidentiality.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have read and/or received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________ Date of Birth: _____________________

Relationship to Patient: ____

Signature: ____ Date: _________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:

Date: _________________ Initials: __________________

Colon & Rectal Surgery Consultants: Patient Registration Forms Page 7/11
Chief Complaint/Patient Agenda for Your Visit/Family History/Social History

Patient Name: ____

What are important questions/issues you would like addressed today?

1. ____
2. ____
3. ____
4. ____

Our desire is to keep Primary Care Physicians and Referring Physicians informed of our findings and plans. Who is your primary care physician? If you see a Nurse Practitioner or Physician's Assistant please list them as well.

1. ____
2. ____

Who referred you for today's visit: ______________________________

FAMILY HISTORY

Has anyone in your family had colon cancer? _______YES _________NO
If yes, please list their relationship to you and how old they were when diagnosed with colon cancer:____
____
Is there a family history of colon polyps in your primary relatives (mother, father, brothers, sisters, children) ________ YES ________ NO

Other family history/concerns involving close relatives. Circle all that apply:
Breast Cancer Crohn's Disease Hemophilia Ovarian Cancer
Pancreatic Cancer Ulcerative Colitis Uterine cancer Endometrial Cancer

SOCIAL HISTORY

Marital Status: _____ Single ____ Married _____Divorced ____Widowed
Who do you live with: ____
Are you ______Retired ______Disabled ______Currently working
Occupation: ____
Alcohol Use: ________ YES __________ NO
Tobacco Use: ______NO __________YES: Please circle: Cigarettes Cigars Dip/Chew
How much daily? ____

Medical History

Patient Name: ____

Circle any of the following problems you are experiencing:

Rectal Bleeding: Black, tarry stools Blood mixed with stool Dark red blood Bright red blood Bleeding with clots On toilet paper only In toilet bowl

Rectal Pain: With bowel movement Constant Sporadic

Other Rectal Problems: Fecal Incontinence Hemorrhoid swelling Anal Itching

Abdominal/GI Issues: Abdominal pain Bloating Gas Nausea Vomiting Weight gain Weight Loss Loss of Appetite Fever Night sweats

Change in Bowel Habits: Diarrhea Constipation Straining

Stools per Day: 1 2 3 4 5 6 or more **Stools per week**: 6 5 4 3 2 1 less than 1

Do you use: Stool softeners Fiber Supplements Laxatives MiraLax

Other over the counter products:___________________________________

Diet: High fiber fruits and vegetables Fast food/Processed Foods Coffee Tea Soda/Carbonated beverages Beef/Pork/Chicken Vegetarian Overall poor diet

History of Food Intolerance/Food Allergies:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Medical History

Patient Name: ____

Medications: Please list all prescription medications as well as over the counter supplements. Indicate dose and prescribing schedule:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____

Drug Allergies: Please list the drug and the specific reaction:

1. ____
2. ____
3. ____
4. ____

Pharmacy Information:

Name of Pharmacy: ________________________________

Address of Pharmacy: ________________________________

Phone number of Pharmacy: ____________________________

Medical History

Patient Name: ____

Past Medical History: Please list any/all medical problems you have been diagnosed with during your lifetime:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Past Surgical History: Please list any/all surgeries you have had during your lifetime:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Colon & Rectal Surgery Consultants: Patient Registration Forms Page 11/11
Medical History

Patient Name: ____

Review of Systems: Please check all that apply:

Constitutional Symptoms:
____Yes good general health lately
____Yes feeling poorly or tiring easily (fatigue)
____Yes a fever
____Yes recent change in weight

Head:
____Yes blurred vision
____Yes wears glasses/contacts
____Yes loss of hearing
____Yes sore throat
____Yes nose bleeds
____Yes mouth sores
____Yes swollen glands
____Yes headache

Cardiovascular:
____Yes chest pain or discomfort
____Yes palpitations
____Yes localized swelling of the legs

Neurological:
____Yes lightheadedness
____Yes dizziness
____Yes numbness
____Yes tingling
____Yes nonmoving limbs

Psychiatric:
____Yes confused or disoriented
____Yes nervous or anxious
____Yes feeling depressed
____Yes insomnia

Hematologic/Lymphatic
____Yes bleeding gums
____Yes easy bruising tendency

Respiratory:
____Yes a cough
____Yes coughing up blood
____Yes difficulty breathing
____Yes wheezing

Gastrointestinal:
____Yes decrease in appetite
____Yes constipation
____Yes diarrhea
____Yes bowel urgency
____Yes pain with bowel movement
____Yes unable to hold bowel movement
____Yes blood with bowel movement

Genitourinary:
____Yes pain/burning or urination
____Yes blood in urine
____Yes leakage of urine

Endocrine:
____Yes urine volume has increased
____Yes excessive thirst
____Yes excessive sweating
____Yes temperature intolerance

Musculoskeletal:
____Yes joint pain
____Yes decrease in strength
____Yes muscle cramps
____Yes back pain

Skin & Soft Tissue:
____Yes skin rash
____Yes skin itching
____Yes breast pain
____Yes breast lump
____Yes nipple discharge