NAME: _____ **DOB:** _____

PHARMACY- _____

SUBJECT - What symptoms are you being seen for or what is the reason for your visit at this time?

_____

_____

ALLERGIES - Please list any allergies to medications:

_____

_____

CURRENT MEDICATIONS - Please list all current medications **(Prescriptions & OTC)** with dosages and directions

MEDICATION NAME	SIZE (MG)	TAKE (#)	FREQUENCY	PRESCRIBED BY

HEALTH MAINTENANCE

Please check the line to identify any of the following vaccines or tests (<u>ADD DATES</u>, if known):

COVID Vaccine (dates & type)_____

Flu Vaccine_____

Pneumovax_____

Zosters (Shingles) Vaccine_____

TB Skin Test_____

Blood Glucose_____

Mammogram_____

NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY-SURGERIES

Please check the line to identify any previous major surgical procedures (add dates, if possible):

Appendectomy_____

Cholecystectomy (Gallbladder Removal)_____

Vagotomy/Pyloroplasty (Ulcer Surgery)_____

Gastric Resection (Removal of a Portion of the Stomach)_____

Colon Resection_____

Hiatal Hernia Repair_____

Hysterectomy (Removal of Uterus)_____

Removal of Tubes and Ovaries_____

Coronary Bypass (CABG)_____

Heart Valve Replacement_____

Aortic Aneurysm Repair_____

Angioplasty/Stent Placement_____

Cancer Surgeries_____

Colonoscopy (date of procedure, where it was done) _____

EGD (date of procedure, where it was done) _____

Please List All Other Major & Minor Surgeries w/ Dates:

_____

_____

_____

PERSONAL HABITS

Please comment on personal habits as follows:

Use of alcohol: □ Never □ Rarely □ Moderate □ Daily

beers per week: _____ mixed drinks per week: _____ glasses of wine per week: _____

Use of tobacco: □ Never □ Previously but quit □ Current packs per day ____ □ Years smoking ____

Use of chewing tobacco or snuff: □ Never □ Current cans per day □ Years dipping _____

Drug use: □ Never □ Type/Frequency _____

Caffeine use: □Never □ How many cups coffee/tea/soda/ per day? _____

Marital History: □ Married □ Single □ Divorced □ Widowed

Occupation:_____

NAME: _____ **DOB:** _____

CHRONIC ILLNESSES

Please circle yes or no to identify any chronic illnesses:

Coronary Heart Disease ---------- Yes No

Valvular Heart Disease ---------- Yes No

Hypertension (high blood pressure) ---------- Yes No

Stroke ---------- Yes No

Chronic Bronchitis ----------Yes No

Emphysema----------Yes No

Asthma ---------- Yes No

Tuberculosis ---------- Yes No

Anxiety ----------Yes No

Depression ---------- Yes No

Elevated Cholesterol ----------Yes No

High Triglycerides ----------Yes No

Hiatal Hernia ---------- -Yes No

GERD ----------Yes No

Gallstones ---------- Yes No

Duodenal Ulcer ----------Yes No

Gastric Ulcer ----------Yes No

Pancreatitis ----------Yes No

Hepatitis A / B / C (circle one)---------- Yes No

Ulcerative Colitis ----------Yes No

Crohn's Disease ---------- Yes No

Epilepsy ---------- Yes No

Anemia ---------- Yes No

Diabetes ---------- Yes No

Hypothyroidism ---------- Yes No

Hyperthyroidism ---------- Yes No

Cancer ---------- Yes No (What type? _____)

***IF YOU ARE 65 OR OLDER HAVE YOU HAD A RECENT FALL?** (Within the last 3 months) Yes No

NAME: _____ **DOB:** _____

REVIEW OF SYSTEMS-FAMILY HISTORY

Please indicate below if any of your family members have had the following illnesses using these abbreviations: M=Mother, F=Father, S=Sister, B=Brother, CH=Child, MGM=Maternal Grandmother, PGM=Paternal Grandmother, MGF=Maternal Grandfather, PGF=Paternal Grandfather, PU=Paternal Uncle, MU=Maternal Uncle, PA=Paternal Aunt, MA=Maternal Aunt.

Crohn's Disease_____

Ulcerative Colitis_____

Colon Cancer_____

Colon Polyps_____

Liver Disease _____

Pancreatitis_____

Gallstones_____

Esophagus Cancer_____

Stomach Cancer_____

Pancreas Cancer_____

PHYSICAL EXAM-SUPPLEMENTAL INFO

Please circle your current problems or symptoms:

RESPIRATORY: Chronic Cough Production of Sputum Pain Aggravated by Deep Breathing

CARDIOVASCULAR: Irregular Heart Beat Aching/Squeezing Chest Pain: with exertion/at rest
Shortness of Breath: with exertion/at rest/when lying flat Ankle Edema Leg Pain with Walking

GASTROINTESTINAL: Loss of Appetite Abdominal Pain Cramping Nausea Vomiting Rectal Bleeding
Bloody Stool Black Tarry Stool Anal Pain Anal Pain w/Bowel Movement Change in Bowel Habits Constipation
Diarrhea Difficulty Swallowing Heartburn Stool Incontinence Reflux/Regurgitation Indigestion Jaundice
Vomiting Blood Belching Gets Full Quickly at Meals Bloating Chronic Diarrhea Excessive Gas Painful Swallowing

SCREENING COVID-19 QUESTIONAIRE (circle YES or NO)

*****Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches or shortness of breath for unknown reason, loss of smell, loss of taste, fever at or greater than 100 degrees? **YES or NO**

*****Have you or anyone in your household been tested for COVID-19? **YES or NO**

*****Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? **YES or NO**

*****Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? **YES or NO**

Thank you for completing this form. If time permits, please mail it back to our office at your earliest convenience. Failing to complete this form prior to your appointment will cause your appointment to be delayed. We look forward to seeing you soon.

COLORECTAL SURGICAL & GASTROENTEROLOGY ASSOCIATES, PSC

Colorectal Dept: Drs. David Svetich, Charles Papp, John Dvorak, Bruce Belin, Jennifer Rea & Frank Rutigliano

859-278-6031 fax 859-277-7015

Gastro Dept: Drs. Stephen Schindler, Nathan Massey & Thomas Knopp

859-278-8486 fax 859-278-8488

2620 Wilhite Drive, Lexington, KY 40503

www.csgaky.com

Patient Name:

DOB:

Consent for Use and Disclosure of Patient Information for the Purposes Of Treatment, Payment and Health Care Operations

I do hereby consent to **Colorectal Surgical and Gastroenterology Associates** (the "Practice) using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services to me or to carry out the Practice's healthcare operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Records Expressly Included: I expressly authorize release of the following information for the purpose and treatment, payment, and healthcare operation, if it is part of my protected health information (CHECK ANY AND ALL THAT YOU AGREE TO AUTHORIZE FOR RELEASE):

- □ Chemical Dependency/Substance Abuse
- □ Drugs
- □ Alcohol
- □ Sexually Transmitted Diseases

I further acknowledge the Practice has provided me with a copy of it's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

****Please list below any family members/friends that you allow to have access to your personal health record****

CSGA REGISTRATION FORM

Full Name: *(Including middle initial)* **Full Mailing Address:** *(Including city, state, zip)*		
Phone (Home):	**Phone (Work):**	**Phone (Cell):**
Date of Birth:	**SS#:**	**Gender:**
Occupation:	**Employed By:**	
Email Address:	**Preferred Method of Contact:** *please circle one* Phone Email Letter No Preference	
Race: *please circle one* White Black/African American Asian American Indian/Alaska Native Native Hawaiian Other Pacific Islander More than 1 race Refuse to report		
Ethnicity: *please circle one* Hispanic/Latino Not Hispanic/Latino Refuse to report		
Language: *please circle one* English Spanish Other (specify):		
Pharmacy:	**Primary Care Physician:**	**Referring Physician:**

If Patient is Under 18, Person Responsible for Bill

Name: **SS#:** **DOB:**	**Relationship to Patient:**
Mailing Address: *(Including city, state, zip)*	**Phone:**

Name and phone number of closest relative not living with you or Emergency Contact with number different from above

Name:	**Phone:**

Insurance Information

Primary:	**Policy Holder:**	**Date of Birth:**
Address:	**ID#:**	**Group #:**
Secondary:	**Policy Holder:**	**Date of Birth:**
Address:	**ID#:**	**Group #:**

I authorize Colorectal Surgical & Gastroenterology Associates to release any information needed to determine payment benefits or the benefits payable for related services to: any person, company, or entity (including, but not limited to HMOs, insurance companies, works' compensation carriers, the Centers for Medicare and Medicaid Services and its agents, or any other payer or review organization or third party administrator) that is or may be liable for paying a claim for benefits arising out of services provided to me. I authorize Colorectal Surgical & Gastroenterology Associates to submit claims for payment as necessary for services rendered to me and authorize payment to Colorectal Surgical & Gastroenterology Associates for services rendered. In order to be respectful of the medical needs of other patients, please remember to call within 48 hours to cancel or reschedule your appointment for any reason in order to allow us to reallocate this time to someone who is in need of treatment. Appointments are in high demand and unfortunately a $30.00 no show or late cancellation fee for office visits & a $100.00 fee for procedures will be charged to your account if we do not hear from you in a timely manner. By signing below, I am authorizing treatment. I permit a copy of this authorization to be used in place of the original and reserve the right to revoke this authorization in writing at any time.

Patient Signature, or if under 18 Personal Representative **Date**