ALABAMA COLON & RECTAL INSTITUTE, P.C.
REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's Last Name, First Name, MI	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	❑ DR ❑ SR ❑ JR ❑ III	Marital status (check one) ❑ Single ❑ Married ❑ Divorced	❑ Separated ❑ Widowed ❑ Widower

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Primary Phone #: ( )	Alternative #: ( )

P.O. Box:	City:	State:	ZIP Code:	Social Security no:

E-mail Address:	❑ I do not have an E-mail Address

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:

INSURANCE INFORMATION

Do you have health insurance? ❑ Yes ❑ No, I will be paying out of pocket for my visits

Person responsible for bill: (if other than self)	Birth date: / /	Address (if different):	Telephone #: ( )

Employer:	Employer Address:	Employer phone no.: ( )

Please indicate primary health insurance: ❑ MEDICARE ❑ BCBS ❑ UNITED HEALTH ❑ VIVA HEALTH ❑ CIGNA
❑ AETNA ❑ TRI-CARE ❑ HUMANA ❑ HEALTHSPRINGS ❑ Other:

Policy/Contract #:	Group #:	Subscriber's name (if other than self):	Date of Birth:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Policy/Contract #:	Group no.:	Subscriber's name (if other than self):	Date of Birth:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Primary Contact #: ( )	Alt. Contact #: ( )

The above information is true to the best of my knowledge.

I authorize ALABAMA COLON & RECTAL INSTITUTE, P.C. or my insurance company to release any information required to process my claims.

_____

Patient/Guardian signature: ***Date:***

ALABAMA COLON AND RECTAL INSTITUTE, P.C.

I/We hereby agree as follows:

GUARANTEE OF PAYMENT: Medical care has been or will be provided to the patient whose name appears below. I/We, both jointly and individually, shall be fully responsible for payment for the patient's physician bill, based upon the physician's posted charges, which I/We agree are fair and reasonable. The physician may demand full payment of the patient's bill at any time.

ASSIGNMENT OF INSURANCE BENEFITS: I/We hereby authorize payment directly to Alabama Colon and Rectal Institute, PC of benefits including major medical insurance and payment of medical or surgical benefits for those services rendered. I /We understand that I/We are financially responsible to Alabama Colon and Rectal Institute, PC for charges not covered by this assignment. I/We authorize the refund of overpaid insurance benefits where coverage is subject to coordination of benefits.

IN THE EVENT OF DEFAULT: Should collection action become necessary, I/We agree to pay all costs of collection, including all reasonable attorney's fees and waive all rights to claim personal property exempt under the laws of the State of Alabama and any other state.

I/We have read and understood this Agreement and have received a copy as well.

Patient Signature:	**Date:**

Name of Primary Person Guaranteeing Payment:	
Signature:	
Relationship to Patient:	
Social Security Number:	
Date of Birth:	
Home Address:	
Employer:	
Employer's Phone Number:	

Name of Secondary Person Guaranteeing Payment (if applicable):	
Signature:	
Relationship to Patient:	
Social Security Number:	
Date of Birth:	
Home Address:	
Employer:	
Employer's Phone Number:	

ALABAMA COLON AND RECTAL INSTITUTE, P.C.

A PROFESSIONAL CORPORATION
1317 4TH Ave South
Birmingham, AL 35233

Patient Name *(Last, First, M.I.):*	☐ M ☐ F **DOB:**

HIPAA RELEASE OF INFORMATION	
Should I need to be contacted from ALABAMA COLON AND RECTAL INSTITUTE, a message may be left to my voicemail or answering machine.	❑ Yes, you **MAY** leave a message ❑ No, you **MAY NOT** leave a message
My medical information and/or test results in relation to ALABAMA COLON AND RECTAL INSTITUTE, P.C. may be released to:	❑ Patient **ONLY** ❑ the following person(s)
Name:	Phone #: ( )
Name:	Phone #: ( )
Name:	Phone #: ( )

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THE **ALABAMA COLON AND RECTAL INSTITUTE, P.C.** PRIVACY NOTICE.

Privacy notice is provided under the 'patients' tab on website or during sign-in at the office.

Patient/Guardian signature: ***Date:***

RELEASE OF MEDICAL RECORDS:

I AUTHORIZE ALABAMA COLON AND RECTAL INSTITUTE, P.C. TO REQUEST OR RELEASE ANY MEDICAL INFORMATION FROM/TO ANOTHER PHYSICIAN OR MEDICAL INSTITUTION AS NECESSARY FOR MY MEDICAL CARE.

Patient/Guardian signature: ***Date:***

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	☐ M ☐ F	**DOB:**
Primary Physician:	Referring Physician:	

REASON FOR VISIT		
I am here today to: ☐ schedule a colonoscopy	☐ schedule a surgery	☐ be seen for a problem I have been having
Briefly describe your problem:		
When did this problem start?	What makes this problem worse?	
What makes this problem better?		

PERSONAL HEALTH HISTORY	
Do you have a history of colon polyps? ☐ No ☐ Yes	**Do you have a history of colon cancer?** ☐ No ☐ Yes
Does a relative have a history of colon polyps? ☐ No ☐ Yes	If yes, their relation to you:
Does a relative have a history of colon cancer? ☐ No ☐ Yes	If yes, their relation to you:
Have you ever had a colonoscopy? ☐ No ☐ Yes	If yes, date of last colonoscopy:
Physician who performed colonoscopy:	Results of colonoscopy: ☐ Normal ☐ Polyps ☐ Other:

Previous Surgeries		
Year	Type	Hospital or Facility

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

HEALTH HABITS						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If so, how often do you drink alcohol? ☐ Rarely ☐ Moderate ☐ Daily					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day:_____	☐ Chew - #/day:_____	☐ Pipe - #/day:_____	☐ Cigars - #/day:_____		
	☐ # of years you have smoked/chewed:____	☐ Previously smoked, but quit ____ years ago				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	If yes, please specify what drug(s):					

FAMILY HEALTH HISTORY							
	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandmother** *Maternal*			
	☐ M ☐ F			**Grandfather** *Maternal*			
	☐ M ☐ F			**Grandmother** *Paternal*			
	☐ M ☐ F			**Grandfather** *Paternal*			

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies:_____ # of vaginal births:_____ # of C-sections:_____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam:		
Date of last mammogram screening:		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate (PSA) and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had any of the following diseases or disorders:

DISEASES/DISORDERS

☐ Diabetes	☐ Kidney Disease	☐ Sleep Apnea If yes, C-PAP? ☐ Yes ☐ No
☐ Hypertension	☐ High Cholesterol	☐ Asthma
☐ Cancer Type:	☐ Psychiatric Illness	☐ Arthritis/Gout
☐ Stroke	☐ Liver Disease/Hepatitis	☐ Thyroid Disease
☐ Heart Disease	☐ Reflux	☐ Colitis
☐ Diverticulitis	☐ HIV/AIDS	

OTHER:

Check if you have, or have had any symptoms in the following areas

CONSTITUTIONAL

☐ Recent weight loss	☐ Fever	☐ Fatigue
☐ Excessive thirst	☐ Excessive urination	

EYES

☐ Eye disease or injury	☐ Blurred or double vision	☐ Temporary loss of vision

ENT

☐ Hearing loss	☐ Ringing in the ears	☐ Sinus difficulties
☐ Nosebleeds	☐ Bleeding gums	☐ Swollen glands in neck

CARDIOVASCULAR

☐ Heart trouble	☐ Chest pains	☐ Sudden heartbeat changes
☐ Swelling of feet, ankles or hands		

RESPIRATORY

☐ Frequent coughing	☐ Spitting up blood	☐ Shortness of breath
☐ Asthma or wheezing		

GASTROINTESTINAL

☐ Loss of appetite	☐ Nausea	☐ Vomiting
☐ Frequent diarrhea	☐ Painful bowel movements	☐ Constipation
☐ Blood in stool	☐ Stomach pain	☐ Fecal incontinence
☐ Rectal pain		

GENITOURINARY

☐ Burning or painful urination	☐ Blood in urine	☐ Kidney stones
☐ Sexual difficulty		

MUSCULOSKELETAL

☐ Joint pain	☐ Weakness of muscles or joints	☐ Muscle pain or cramps
☐ Back pain	☐ Cold extremities	☐ Heat or cold intolerance
☐ Difficulty in walking	☐ Head/neck pain	

SKIN

☐ Rash or itching	☐ Varicose veins	☐ Breast pain

NEUROLOGICAL

☐ Frequent or reoccurring headaches	☐ Lightheaded or dizzy	☐ Convulsions or seizures
☐ Numbness or tingling sensations	☐ Tremors	☐ Paralysis
☐ Head injury		

PSYCHIATRIC

☐ Memory loss or confusion	☐ Nervousness	☐ Depression
☐ Sleep problems	☐ Anxiety disorders	

HEMATOLOGIC/LYMPHATIC

☐ Slow to heal after cuts	☐ Easily bruise or bleed	☐ Anemia
☐ Phlebitis/blood clots	☐ Enlarged glands	

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**

Pharmacy:		
Name of Pharmacy	*Location (City and/or Street)*	*Phone Number*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name the Drug	*Strength*	*Frequency Taken*
Allergies to medications	☐ **No known drug allergies**	
Name the Drug	*Reaction You Had*	
Vaccinations:		
Pneumonia Vaccine	**Approximate date:**	
Flu Vaccine	**Approximate date:**	