



**PATIENT REGISTRATION FORM
WELCOME TO OUR PRACTICE**

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
PLEASE PRINT. ALL INFORMATION WILL BE CONFIDENTIAL.

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____	AGE _____	DATE OF BIRTH _____
ADDRESS _____	SEX _____	MARITAL STATUS _____
CITY _____	STATE _____	ZIP _____
HOME PHONE _____	EMAIL ADDRESS: _____	
CELL PHONE _____	REFERRED BY WHOM _____	
SOCIAL SECURITY # _____	PRIMARY PHYSICIAN _____	
EMPLOYER _____	PERMANENT ADDRESS (IF DIFFERENT)	
ADDRESS _____	ADDRESS _____	
CITY _____	STATE _____	ZIP _____
WORK PHONE _____	PHONE # _____	
PHARMACY NAME & PHONE _____	OCCUPATION _____	

WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS UNDER FEDERAL GUIDELINES. IF YOU CHOOSE "I PREFER NOT TO ANSWER" PLEASE BE ASSURED THAT NO ADVERSE ACTION WILL BE TAKEN BY ANYONE IN THIS OFFICE.

****RACE** _____ ****ETHNICITY** _____ **LANGUAGE** _____ **I PREFER NOT TO ANSWER** _____ ******

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME _____	BIRTH DATE _____
SOCIAL SECURITY # _____	RELATION TO PATIENT _____

PERMISSION FOR VERBAL COMMUNICATIONS

I permit Hemorrhoid Center of Arizona, its physicians, nurses and other personnel to discuss health, medical, and/or billing information, in person or by telephone or in writing, with the following individuals listed below. (List individuals and state the person's relationship to the patient):

OR

I decline to give a name at this time

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

If, at any time, I do not want verbal discussions to be permitted between Hemorrhoid Center of Arizona and any of the individuals named above, I must notify Hemorrhoid Center of Arizona in writing or by calling (623) 440-6591 and speaking with the Practice Office Manager.

*****Signature** _____ **Date** _____

Medical History

Name _____ Today's Date _____

Reason for Today's Visit _____

HEALTH QUESTIONNAIRE Please check the boxes if you have ever been diagnosed with.
Please read carefully and underline which type.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Alcoholism
<input type="checkbox"/> Alzheimer
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Blood Disorders or Anemia
<input type="checkbox"/> Bronchitis (Current)
<input type="checkbox"/> Cancer-specify _____
<input type="checkbox"/> Cataracts(list surgery below)
<input type="checkbox"/> Other Medical History _____ | <input type="checkbox"/> Colitis
<input type="checkbox"/> Colonic Polyps
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> COPD
<input type="checkbox"/> Dementia
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes (type 1/type 2)
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Eczema
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Fibrocystic Breast Disease
<input type="checkbox"/> Fissure
<input type="checkbox"/> Gallstones | <input type="checkbox"/> Glaucoma
<input type="checkbox"/> GERD
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Failure
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV
<input type="checkbox"/> Hypothyroidism/Hyper
<input type="checkbox"/> Incontinence (fecal/urinary)
<input type="checkbox"/> Irregular Heart Beat-specify _____
<input type="checkbox"/> Kidney Disease/Stone | <input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Mental Illness-specify ____
<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Pneumonia (current)
<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Seizures
<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Gastric Ulcers
<input type="checkbox"/> Urine Infections |
|---|---|--|--|

Current Problems?

	Yes	No		Yes	No		Yes	No
Weight Loss/Gain	___	___	Joint Pain	___	___	Change in bowels	___	___
Fever	___	___	Joint swelling	___	___	Constipation	___	___
Fatigue	___	___	Skin rash	___	___	Abdominal Pain	___	___
Hearing change	___	___	Headaches	___	___	Diarrhea	___	___
Nose bleeds	___	___	Dizziness	___	___	Rectal Bleeding	___	___
Visual change	___	___	Insomnia	___	___	Dark stools	___	___
Sore throat	___	___				Rectal Pain	___	___
Chest Pain	___	___	Urinary frequency	___	___	Rectal Burning	___	___
Shortness of breath	___	___	Burning	___	___	Rectal Itching	___	___
Wheezing	___	___	Blood in urine	___	___	Fecal Incontinence	___	___
						Nausea	___	___
						Vomiting	___	___

LIST ALL THE MEDICATIONS, DOSAGE AND FREQUENCY TAKEN

***If you have a copy of your list of medications, please give a copy to the front desk.
(If more space is needed please ask the front desk for another form.)***

Medication Name	Dosage (mg)	Frequency (daily, tablets or capsules)

List more on the back side of this sheet. Thank You.

Medication Allergies and reactions: _____

Type of Allergy: **Latex** **Iodine** **Contrast**

HEALTH SCREENING

Have you ever had a mammography? (Indicate date and results) _____

Have you ever had a colonoscopy/flexible sigmoidoscopy? (Indicate date, results & MD) _____

Have you ever had a prostate screening or PSA level? (Indicate date, results & MD) _____

SURGICAL HISTORY & Years

- Appendectomy _____
- Breast Surgery _____
- Gall Bladder Removal _____
- Hernia Repair _____
- Cardiac Cath _____
- Pacemaker _____
- Heart Stent(s) _____
- Hysterectomy _____
Complete or Partial _____
- Colon/Small Bowel _____
(Specify) _____
- Previous Anorectal Surgery _____
(Specify) _____

Other Surgeries or Procedures & Years

FAMILY HISTORY

Colorectal Cancer Family member affected: _____

Other Cancers in the family:

- Breast Prostate Stomach Uterine Ovarian Brain Bladder

Other (Specify) _____

No family history of malignancies

Any Falls in the last year? Yes No # injury with fall? _____

OTHER FAMILY MEDICAL DISORDERS

Specify: F-Father, M-Mother, B-Brother, S-Sister, D-Daughter, SS-Son

- | | | |
|----------------------------|------------------------------|---------------------------------|
| Bleeding Problems _____ | Kidney Disease _____ | Mother- Alive or Deceased _____ |
| Asthma _____ | Colonic Polyps _____ | Cause of death _____ |
| Hypertension _____ | Diverticulitis disease _____ | Father- Alive or Deceased _____ |
| Hypercholesterolemia _____ | Ulcerative Colitis _____ | Cause of death _____ |
| Diabetes _____ | Crohn's Disease _____ | |
| Heart Attack _____ | Colitis _____ | |

SOCIAL HISTORY

Single Married Divorced/Separated Widowed

Height : _____ft _____in **Weight**: _____lbs

Work Yes No Retired Occupation: _____

Any dietary restrictions: Yes No

Smoke: Yes No Former **Pack/Day** _____

Explain: _____

Social Drugs: _____

Alcohol: Yes No

Monthly # _____ Daily # _____ Socially # _____

OBSTETRICAL AND GYNECOLOGICAL HISTORY

Pregnancies # _____ Children # _____

Last Menstrual Period ____/____/____

Deliveries # _____ C-section _____ Vaginal delivery _____

Last Pap Smear/Pelvic Exam _____

Forceps _____ Episiotomy _____

ALL PATIENTS PLEASE READ AND SIGN

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize Hemorrhoid Center of Arizona to release any information necessary to file a claim with my insurance company and request that payments under my insurance plans be made directly to Hemorrhoid Center of Arizona for any services furnished to me. I understand that I am financially responsible for balances not covered by my insurance carrier.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Self Pay patients understand that they are financially responsible for all services provided by Hemorrhoid Center of Arizona. If necessary, I will set up a payment plan with the office manager.

Financial Arrangements

We offer the following methods of payment: Discover, Visa, Master Card and American Express. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance **prior** to your appointment.

FMLA Forms

We are happy to complete any FMLA Forms as needed. There is a \$25 charge for each & every form to be completed and is due prior to the form being completed. We have 14 days to complete the form.

Appointments

There will be a \$25.00 charge for missed appointments and procedures. (Appointments not cancelled more than 24 hours in advance or "no-shows")

Acknowledgement of Hemorrhoid Center AZ of Arizona Office Policy

I have been presented with a copy of Hemorrhoid Center AZ of Arizona "**Office Policy**". I understand the contents and I agree to its terms.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Hemorrhoid Center AZ of Arizona "**Notice of Privacy Policies**", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restriction(s) concerning my personal medical information:

INFORMED CONSENT

When you become a patient in this office, certain low risk procedures will be performed. As with all medical procedures, there are certain risks involved. Anoscopy, proctoscopy, flexible sigmoidoscopy, polypectomy, hemorrhoidal ligation, drainage of abscess and laser surgery are all low risk procedures often performed in this office. These will all be explained to you in consultation before your examination. If you have questions at any time about what is being done to you, please ask the doctor or office personnel immediately.

Patient Signature: _____ **Date:** _____



Hemorrhoid Center Arizona

Phone: ##### Fax: #####

Your provider may perform an Anoscopy procedure as part of your evaluation, this may be necessary to obtain a diagnosis and for treatment purposes. This will be billed to your insurance; however, Insurance plans consider this a surgical procedure it is a separate fee from the office visit and the Insurance may apply this fee towards your deductible/coinsurance so you may be responsible for an additional amount after the claim is processed.

An Anoscopy is a simple procedure where a small instrument (anoscope) is inserted into the rectum. This allows your provider to identify any abnormalities in the anorectal area. The procedure is very brief, with minimal discomfort. Your provider will review this further with you if this needs to be performed.

Patient Name: _____

Patient DOB: _____

Patient Signature: _____ Date: _____