

NEW REGISTRATION  UPDATED

EIN 20-1505116

ARIZONA ASSOCIATED SURGEONS, PLLC

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Charles E. Castillo, MD             | <input type="checkbox"/> Richard J. Harding, MD | <input type="checkbox"/> Brett I. Siegrist, MD |  |
| <input type="checkbox"/> William R. Friese, MD               | <input type="checkbox"/> David C. Johnson, MD   | <input type="checkbox"/> Edward H. Charles, MD | <input type="checkbox"/> Douglas J. Carlon, MD |
| <input type="checkbox"/> Ravia B. Bokhari, MD                | <input type="checkbox"/> Sandra B. Gladding, MD | <input type="checkbox"/> Jon A. King, MD       |  |
| <input type="checkbox"/> Adrienne W. Forstner-Barthell, M.D. | <input type="checkbox"/> Keith G. Zacher, MD    | <input type="checkbox"/> Jeromy S. Brink, MD   |  |

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #
HOME ADDRESS			CITY	STATE	ZIP
			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
HOME PHONE #	EMAIL	CELL PHONE #	MARRIED STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		
REFERRING PHYSICIAN NAME AND ADDRESS AND ZIP			REFERRING PHYSICIAN PHONE#		

**MANDATORY-PER NEW CMS GUIDELINES**

<b>LANGUAGE</b> <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> CREOLE <input type="checkbox"/> FRENCH <input type="checkbox"/> PORTUGUESE <input type="checkbox"/> JAPANESE	<b>ETHNICITY</b> <input type="checkbox"/> LATINO/HISPANIC <input type="checkbox"/> NON LATINO/NON HISPANIC	<b>RACE</b> <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> REFUSE TO REPORT
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**RESPONSIBLE PARTY INFORMATION (financial responsibility)**

LAST NAME	FIRST NAME	MI	HOME PHONE
ADDRESS	CITY	STATE	ZIP
EMPLOYER		OCCUPATION	WORK PHONE
EMPLOYER ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			

**EMERGENCY INFORMATION**

NEXT-OF-KIN OR CONTACT INFO - OTHER THAN SPOUSE/RELATIONSHIP	PHONE
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**PHARMACY**

NAME AND LOCATION	PHONE
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**INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION**

<b>PRIMARY INSURANCE</b>	<b>SUBSCRIBER NAME AND SOCIAL SECURITY</b>	DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER			
ADDRESS	CITY	STATE	ZIP	PHONE
<b>SECONDARY INSURANCE</b>	<b>SUBSCRIBER NAME AND SOCIAL SECURITY</b>	DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER			
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

**ASSIGNMENT OF BENEFITS AND RECORDS RELEASE**

**ASSIGNMENT OF BENEFITS**

I understand I am financially responsible for services rendered regardless of insurance or other third party payer. Unpaid balance subject to collection fees of 30%, as well as legal fees if applicable. Also, I understand that I may be financially responsible for a surgery cancellation fee of up to \$150 should I fail to cancel/reschedule at least 24 hours in advance.

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

X \_\_\_\_\_  
Patient Signature or Signature of Guardian or Parent Date

**RECORDS RELEASE**

I hereby authorize Arizona Associated Surgeons PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X \_\_\_\_\_  
Patient Signature or Signature of Guardian or Parent Date

**Colon and Rectal Center of Arizona**  
**Contact Information**

Name \_\_\_\_\_

I may be contacted in the following manner (circle all that apply):

OK to leave message with detailed information: Home Work Cell No

OK to leave call back number only: Home Work Cell No

OK to send mail to: Home Work

OK to fax information to: Home Work

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_

Information may be left with me or the following individuals:

\_\_\_\_ Spouse Name & birthdate \_\_\_\_\_

\_\_\_\_ Other Name & birthdate \_\_\_\_\_

**Office Policies**

**Initial**

**Medical Records**

When requesting copies of your medical records please allow 48-72 business hours to process.

\_\_\_\_\_

**Disability Forms**

There will be a \$20.00 completion and processing fee for all forms needing to be completed related to disability. Please also allow 48-72 business hours for these.

\_\_\_\_\_

**Office Cancellation/Reschedule**

If you cancel or reschedule an office visit more than 2 times without notifying our office at least 24 hours in advance, you will be released from our practice and we will no longer be able to provide care for you.

\_\_\_\_\_

**Surgery Cancellation/Reschedule**

If you are scheduled for a colonoscopy, procedure or surgery of any kind and you need to cancel or reschedule, you may be subject to a \$100.00 surgery rescheduling fee.

\_\_\_\_\_

**Acknowledgement of Receipt of Privacy Notice**

*Original to be maintained in patient's permanent medical record*

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

\_\_\_\_\_

\_\_\_\_\_

Patient or legally authorized individual signature

Date

\_\_\_\_\_

\_\_\_\_\_

Printed Name

Relationship (self, parent, legal guardian, etc)

# Colon and Rectal Center of Arizona

Name \_\_\_\_\_

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

What is your reason for seeing the doctor (please be specific): \_\_\_\_\_

Primary doctor \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

## Past Medical and Surgical History

Please circle yes or no to the following:

Anal Pain?	Yes or No	How long have you had this? Is it constant? Come and go? Worse with bowel movement? How long does it last?
Bleeding from the anus?	Yes or No	Bright red? Dark red? Black?
Rectal protrusion?	Yes or No	
Rectal swelling?	Yes or No	
Itching at the anus/rectum?	Yes or No	
Burning at the anus or rectum?	Yes or No	
Hemorrhoids	Yes or No	What problems do your hemorrhoid cause for you?
Rectal discharge?	Yes or No	
Mucous in bowel movements?	Yes or No	
Do you use medications in anal area?	Yes or No	What medications?
Do you have trouble holding your bowels?	Yes or No	Does the problem include solid stool, liquid stool, and/or gas? Are you able to hold an enema? How often does the trouble occur?
Do you have soilage?	Yes or No	How often?
Have your bowel habits changed recently?	Yes or No	How have they changed?
Are you constipated?	Yes or No	How many BM's per week? Do you require enemas? How often? Do you require laxatives? How often? Which ones?
Any history of sexually transmitted diseases?	Yes or No	Which ones? When?
Do you have abdominal pain?	Yes or No	Where is the pain located? How long has the pain been there?
Have you lost weight recently?	Yes or No	How much? Intentional?

Have you had any of the following tests or procedures?

Test	Yes or No?	Date
Electrocardiogram	Y or N	
Upper GI (stomach endoscopy)	Y or N	
Colonoscopy	Y or N	
Flexible Sigmoidoscopy	Y or N	
Barium Enema	Y or N	

**Colon and Rectal Center of Arizona**

Name \_\_\_\_\_

**Previous Operations: (please be specific as to reasons and dates)**

Operation	Date & Reason for Operation

**Medical Problems and Hospitalizations: (including high blood pressure, seizures, cancer, diabetes, heart disease, liver disease, thyroid disease asthma, stroke, hepatitis, HIV, intestinal bleeding)**

Please list Medical Problems and Hospitalizations	Reason & Date

**Additionally, please answer the following:**

Have you had a heart attack? When? Cardiologist?	
Do you have or have you been diagnosed with sleep apnea? Do you use a CPAP machine?	
Do you have bleeding disorders or bleeding tendencies?	
Do you have a history of abnormal blood clotting?	

**Medications**

Medication with Dosage and Frequency	Medication with Dosage and Frequency

**Additionally, please answer the following:**

Do you use coumadin, aspirin, or blood thinners?	
Have you used steroids in the last year?	
Have you or anyone in your family had a bad reaction to anesthesia?	

**Allergies (medications, etc)**

Substance (medication, food, etc)	Date and Type of Reaction

**Social History and Habits**

Place of birth? \_\_\_\_\_ Where do you live? \_\_\_\_\_ How long? \_\_\_\_\_

Currently Married or Serious Relationship? Y or N      Single?      Divorced?      Widowed?      Widower?

Current occupation? \_\_\_\_\_ Previous occupation? \_\_\_\_\_

Recent travel abroad? \_\_\_\_\_ Where? \_\_\_\_\_

Please circle Yes or No to the following. If yes, provide details.

Do you smoke tobacco now or have you recently quit?	Y or N	How much per day? How many years? When did you quit?
Do you drink alcohol?	Y or N	Do you drink every day or most days? How many glasses/cans per day?
Do you drink beverages with caffeine?	Y or N	How much per day?
Do you use "illegal" drugs?	Y or N	What do you use and how much?
Sexual Orientation (please circle)	Heterosexual    Homosexual Bisexual      Asexual	Number of partners?

**Family History**

Please indicate your family history:

	Colon Polyps	Colon Cancer	Ulcerative Colitis/Crohn's Disease	Other Cancers (breast, ovarian, gastric, etc)
You				
Mother				
Father				
Sister (s)				
Brother (s)				
Daughter (s)				
Son (s)				

Please indicate Father's or Mother's side of the family:

	Colon Polyps	Colon Cancer	Ulcerative Colitis/Crohn's Disease	Other Cancers (breast, ovarian, gastric, etc)
Grandmother	F M	F M	F M	
Grandfather	F M	F M	F M	
Aunt (s)	F M	F M	F M	
Uncle (s)	F M	F M	F M	
Cousin (s)	F M	F M	F M	

**Review of Systems**

Please circle items that relate to your health:

Medical Staff Review Notes:

**Constitutional**

Weight loss      Fatigue      Fever

**Eyes**

Glasses/contacts      Pain      Double Vision  
Glaucoma      Cataracts

**Ear, Nose, Throat**

Ringing in ears      Vertigo      Hearing loss

**Cardiovascular**

Chest Pain      Palpitations      Hypertension  
Fainting Spells      Swelling Ankles/Other

**Respiratory**

Shortness of Breath      Coughing Blood      Wheezing  
Asthma      Chills

**Gastrointestinal**

Heartburn      Nausea/Vomiting      Difficulty Swallowing  
Jaundice

**Genitourinary**

Pain Urinating      Burning      Frequency  
Nighttime      Blood in Urine      Difficulty Urinating  
Abnormal Discharge      Sexually Transmitted Diseases  
Female:      Vaginal Discharge      # Pregnancies \_\_\_\_\_  
# Living Births \_\_\_\_\_      # Miscarriages \_\_\_\_\_  
# Vaginal Deliveries \_\_\_\_\_      # C-sections \_\_\_\_\_  
Last Pap Smear: \_\_\_\_\_

**Musculoskeletal**

Arthritis      Claudication

**Skin**

Rash/Sores      Lesions      Itching      Burning

**Neurological**

Seizures      Weak/Paralysis      Numbness      Memory Loss

**Psychiatric**

Difficulty Sleeping      Anxiety      Depression      Mood Swings

**Endocrine**

Loss of Hair      Heat/Cold Intolerance      Change in Nails      Diabetes  
Thyroid Problems

**Hematologic**

Easy Bruising      Gums Bleed Easily      Enlarged Glands      Prolonged Bleeding

**Allergic/Immunologic**

Hay Fever      Hives/Eczema      HIV/AIDS