MANHATTAN COLORECTAL SURGEONS, LLC
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New York, NY 10022
T: (212) 675-2997
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Today's Date_____

Last Name_____ First Name_____

Social Security #:_____/_____/_____ Sex (M/F)_____

Date of Birth_____/_____/_____Age_____

Address_____Apt#_____Home Phone # (_____) _____

City_____State__ _Zip_____ Cell Phone # (_____) _____

Occupation _____ Work Phone # (_____)_____
Employer_____ Address_____
Preferred E-Mail address_____
Emergency Contact_____ Phone #_____

Referring Doctor_____ Address_____
Referring Doctor's Phone#_____ Referring Doctor's Fax#_____

Primary Insurance_____ ID#_____ Group #_____

Name on Policy if different than patient_____

Secondary Insurance_____ ID#_____Group#_____

Name on policy if different than patient_____

I understand that this office does not automatically accept assignment on insurance, unless you are a member of a managed care or HMO in which the Doctors are participants. I will be responsible for payment in full for all services not covered by the insurance -- including deductibles, co-payments, and coinsurance. I also understand that insurance claims will be processed by **Preferred Health Resources**, a third party billing agency, in compliance with HIPAA (Health Insurance Portability and Accountability Act) guidelines. I authorize the payment of medical benefits to the above Doctors for services rendered. _____ (*Initial*) *

I am aware of the **Cancellation Policy**, which requires **24 hour notice** for any cancelled or rescheduled office visit and **48 hour notice** for any cancelled or rescheduled procedure, colonoscopy, or surgery. Absent proper notice, I will be charged $20 first missed office visit, $50 second missed office visit and $100 per missed procedure, colonoscopy, or surgery. I understand that these fees are not covered by insurance. _____(*Initial*) *

I have received or read a copy of Manhattan Colorectal Surgeons' **Notice of Privacy Practices**_____(*Initial*)*

Signature_____ Date _____

It is the patient's responsibility to bring a valid referral on the date of his/her appointment.

Preferred Pharmacy Name_____
Pharmacy Address or Location_____
Pharmacy Phone Number: _____
Pharmacy Fax Number: _____

Secondary Pharmacy Name: _____
Pharmacy Address or Location_____
Pharmacy Phone Number: _____
Pharmacy Fax Number: _____

Demographic Information Required by Federal HITECH legislation regarding Electronic Medical Records

Race (please circle)

White/Caucasian American Indian/Alaska Native Black/African American
Native Hawaiian/Pacific Islander Asian Patient Declined

Ethnicity (please circle)

Hispanic/Latino Non-Hispanic/Latino Patient Declined

Primary Language (please circle)

English Spanish French Russian Dutch
Italian German Chinese Japanese Other

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What problem brings you to this office today? Please be as specific as possible._____
_____

Medical History

Have you had any problems with any of the following systems? (Please circle and elaborate in the space below)

- Skin
- Musculoskeletal (Orthopedic, back, etc)
- Eyes
- Breast
- Ears, Nose, Throat, Mouth
- Neurological
- Lungs
- Psychiatric
- Allergies
- Blood (hematologic) or Lymphatic, including HIV
- Digestive (stomach, Intestine, Colon, liver, pancreas)
- Urologic (Kidneys, Bladder, Prostate
- Gynecological (Cervix, Uterus, Ovaries)

_____
_____

Have you had any of the following illnesses or problems? (Please circle)

- Anorectal problems (hemorrhoids, abscess, fissure, fistula, anal warts)
- GI bleeding
- Colitis
- Colon polyps
- Colon or rectal cancer
- Diverticulitis
- Diabetes
- Tuberculosis
- Hepatitis (A/B/C)
- High blood pressure
- Rheumatic fever
- Heart murmur
- Mitral valve prolapse
- Epilepsy/Seizures
- Hypothyroid
- High Cholesterol
- Heart Attack
- Arrythmia
- Stroke

Present Medications (including doses and frequency, if known): _____
_____
Do you take aspirin or ibuprofen, or products that contain them? If so, how often and how recently?_____
_____
Do you take any blood thinners (Coumadin, plavix, lovenox, ticlid)?_____

Allergies to Medication (please state reaction):_____

Have you had previous surgery? Please specify type of surgery and give date or year:_____
_____
Have you ever had chemotherapy or radiation treatments? If so, please give dates and reason:_____
_____

Is there a family history of colitis, colon polyps, or colon or rectal cancer? Please specify diagnosis, relationship to you, and age of your relative at time of diagnosis, if known:_____
_____
Have you ever had a colonoscopy? If so, please give date of most recent, name of doctor, and results:_____
_____

Height (inches) _____ Weight (lbs) _____
Smoking(Y/N/Former) How much per day?_____ Quit when?_____
Caffeine (Y/N) How much per day?(coffee____tea_____cola_____energy drink_____
Alcohol (Y/N) How much per day?_____How much per week?_____ Quit when?_____
Beer_____ Wine_____ Liquor_____

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