

# Patient Information

Please answer all questions fully

Date:

Account Number:

Colon And Rectal Surgeons Of Fairfield

2660 Main Street Suite 302

Bridgeport, CT 06606

Phone: (203) 331-8700

Fax: (203) 335-5819

Patient					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone	

Responsible Party					
Name (Last, First, MI)	Social Security	Birthdate	Sex	Home Phone	
Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone	

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information					
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay	
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay	
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay	

Emergency Contact Information				
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number	

Please List Additional Medical Information

### Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature:

\_\_\_\_\_  
(Signature of insured or authorized person, patient or parent if minor)

Date: / / 2005

\_\_\_\_\_

Please tell us about your **PERSONAL MEDICAL HISTORY:**

	Yes	No		Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Previous Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical History: \_\_\_\_\_

Have you ever seen gastroenterologist? \_\_\_\_\_

**SURGICAL HISTORY:** Please list all previous operations.

**MEDICATIONS:** Please list all medications, including vitamins and dosages.

**ALLERGIES TO MEDICATIONS:**

PLEASE TELL US ABOUT YOUR **Family History** (Please Circle)

**SOCIAL HISTORY:**

- Inflammatory Bowel disease (Crohn's disease or ulcerative coli) Yes / No
- Bleeding Disorders Yes / No
- Colon Cancer or Polyp Yes / No
- Rectal Cancer or Polyp Yes / No
- Breast Cancer Yes / No
- Ovarian Cancer Yes / No
- Uterine Cancer Yes / No
- Pancreas Cancer Yes / No
- Stomach Cancer Yes / No

Cigarette Intake: \_\_\_\_\_  
(cigarettes per day)

Alcohol Intake: \_\_\_\_\_  
(Drinks per day)

Cancers or family conditions \_\_\_\_\_

# PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you want anyone other than yourself to receive information regarding your health information you must complete the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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## COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of personal health information (PHI) has been identified as a national problem causing inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with the government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent and inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

May we leave messages at your home Y \_\_\_ N \_\_\_

work Y \_\_\_ N \_\_\_