# Central Texas Colon and Rectal Surgeons

## Patient Registration and History Form

Are you a(n):

☐ New Patient — If you are a new patient, please fill out all the sections on this form.

☐ Established Patient — If it has been one (1) year since your last visit, please fill out all sections on this form.

**Who is your appointment with today?**

| | | |
|---|---|---|
| ☐ Robert W. Cline, M.D. | ☐ Ernest D. Graves, III, M.D. | ☐ Andrew H. Miller, M.D. |
| ☐ David Fleeger, M.D. | ☐ Thiru V. Lakshman, M.D. | ☐ Amar S. Shah, M.D. |
| ☐ April W. Fox, M.D. | ☐ John S. Mangione, M.D. | ☐ Ricardo L. Solis, M.D. |

**Please describe why you are seeking treatment today:** _____

## Demographic Information

**Name**

Preferred Salutation: Mr. Miss Ms. Mrs. Dr. Other: _____ Sex: M F Marital Status: _____

First: _____ Middle Initial: _____ Last: _____

Address: _____ City: _____ State: _____ Zip Code _____

Date of Birth: _____/_____/_____ Age: Social Security #: _____-____-_____

Employer_____Occupation_____

Preferred Language:_____ Ethnicity: Not Hispanic or Latino Hispanic or Latino

Race (circle one): White Black or African American Asian Hawaiian or Pacific Islander Native American or Alaska Native

Preferred Pharmacy and Location:_____Preferred Lab:_____

Referring Physician;_____Primary Care Physician:_____

Other Physicians involved in your care: _____

## Insurance Information

Primary Insurance_____ID_____Policyholder_____

Secondary Insurance_____ID_____ Policyholder_____

## Contact Information

**Phone**

Home : (___) ___-___ Cell: (___) ___-___ Work: (___) ___-___ Preferred: _____

Email Address: _____ Emergency Contact: _____ **(___) ___-___**

**Do we have permission to:**

| | Yes | No |
|---|---|---|
| Leave a message on your home answering machine? | ☐ | ☐ |
| Leave a message on your work voicemail? | ☐ | ☐ |
| Send a text message to your cell phone (i.e. appointment reminders; announcements)? | ☐ | ☐ |
| Register you for our patient portal? (You will receive an email invitation). | ☐ | ☐ |
| Discuss your medical condition with another individual? | ☐ | ☐ |

*If you answered yes, please indicate whom we can speak with and their relationship to you below.*

**Name** **Relationship** **Phone Number**

_____

_____

_____

## Allergies

☐ No Known Allergies ☐ Yes (Please list any: food, drug, latex, and any other allergy we should know about below)

_____

## Medications

Are you currently taking any medications? ☐ Yes ☐ No

If your answer is yes, please list all of the medications you are taking

| | Medications | Dosage | How Often | | Medications | Dosage | How Often |
|---|---|---|---|---|---|---|---|
| 1 | | | | 6 | | | |
| 2 | | | | 7 | | | |
| 3 | | | | 8 | | | |
| 4 | | | | 9 | | | |
| 5 | | | | 10 | | | |

## Vaccines

Immunizations

Flu Shot: ☐ Yes ☐ No Date of Last Flu Shot: _____

Pneumonia Vaccination: ☐ Yes ☐ No Date of Last Pneumonia Vaccination: _____

## Family History

*Check all that apply*

☐ Anesthesia Complication
☐ Breast Cancer
☐ Colon Cancer:
Who? ☐ Father ☐ Sibling ☐ Mother
☐ Colon Polyps
☐ Crohn's Disease
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Ovarian Cancer
☐ Ulcerative Colitis
☐ Uterine Cancer
☐ Other:
Please list if "Other" checked:

## Social History

Are you married? ☐ Yes ☐ No
Do you have children? ☐ Yes ☐ No
If yes, how many children do you have? _____
Do you consume alcohol? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
Do you smoke now? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No
If yes, how many times a week? _____

## Surgical History

None
Appendectomy
Bladder surgery
Breast
Cataract
Colon | Type? _____
Colonoscopy
Gallbladder Removal
Heart | Type?
Hernia | Location?
Hip
Hysterectomy
Knee | Type? _____
Ovaries Removed
Pacemaker | Defibrillator
Rectal Surgery | Type?
*Circle all that apply:*
abscess, drainage, fistulotomy, hemorrhoid, pilonidal cyst, sphincterotomy, other?
Knee | Type? _____
Pacemaker | Defibrillator
Tonsillectomy
Thyroidectomy
Tubal Ligation
Vasectomy

## Past Medical History

Please check all that apply and explain below

☐ None
☐ Anemia
☐ Anesthesia complications
☐ Anxiety
☐ Asthma
☐ Atrial fibrillation
☐ Back/Spine disorder
☐ Blood transfusions
☐ Cancer (please list type)
☐ Colon polyps
☐ COPD | Emphysema
☐ Crohn's Disease
☐ Depression
☐ Diabetes-Type 1
☐ Diabetes- Type2
☐ Diverticulosis
☐ Diverticulitis
☐ DVT/ blood clot
☐ GI bleeding
☐ GERD/ reflux
☐ Heart disease
☐ Hepatitis A, B, C
☐ HIV | AIDS
☐ HPV | Condyloma
☐ High Blood Pressure
☐ Hypothyroidism
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Kidney Stone
☐ Liver Disease
☐ MI/ Heart Attack
☐ Neurologic Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Pulmonary Embolism
☐ Seizure Disorder
☐ Sleep apnea
☐ Stroke/ CVA
☐ Thyroid disorder
☐ Tuberculosis
☐ Valvular Heart Disease
☐ Varicose Veins/Phlebitis
☐ Ulcerative Colitis
☐ Urinary tract infection/recurrent
☐ Other history / Medical Information

## Current Symptoms

***Please check all that apply and explain below***

| | |
|---|---|
| **Breast:** | ☐ Pain<br>Lump: ☐ Left \| ☐ Right |
| **Cardiovascular:** | ☐ Chest Pain ☐ Fainting ☐ Leg Swelling ☐ Palpitations |
| **Constitutional:** | ☐ Chills ☐ Fatigue ☐ Fever ☐ Poor Appetite ☐ Significant Weight Loss (lbs _____)<br>and anxiety |
| **Dermatology:** | ☐ New Skin Lesions ☐ Suspicious Lesions ☐ Changing Moles ☐ Rash ☐ Itching |
| **Ear, Nose, Throat, and Mouth:** | ☐ Cold Symptoms ☐ Mouth Ulcers ☐ Sleep Apnea ☐ Sore Throat |
| **Endocrine:** | Intolerance to: ☐ Cold ☐ Heat ☐ Unusual Weight Change |
| **Eyes:** | ☐ Eye Pain ☐ Double Vision |
| **Gastrointestinal:** | ☐ Abdominal Pain ☐ Blood w/Stool ☐ Bright-Red Rectal Bleeding ☐ Change in Bowel Habits<br>☐ Constipation ☐ Constantly feel like you need to pass stool ☐ Diarrhea<br>☐ Hemorrhoids that come out ☐ Hemorrhoids that need to be pushed in ☐ Pain with Bowel Movement<br>☐ Reflux / Indigestion ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting<br>Leakage of: ☐ Liquid Stool ☐ Solid Stool ☐ Flatus / Gas ☐ Mucous with Bowel Movement ☐ Stomach Ulcer |
| **Genitourinary:** | ☐ Blood in Urine ☐ Painful Urination ☐ Urine Incontinence ☐ Trouble with Urination<br>☐ Problems with Sexual Function |
| **Neurological** | ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Numbness ☐ Paralysis |
| **Respiratory** | ☐ Cough ☐ Shortness of Breath ☐ Wheezing |
| **Musculoskeletal** | ☐ Back Pain ☐ Arthritis ☐ Muscle Pain |
| **Skin** | ☐ Changing Mole ☐ Itching ☐ Rash ☐ Suspicious Abnormalities |
| **Hematologic / Lymphatic** | ☐ Excessive Bleeding ☐ Excessive Bruising ☐ Enlarged Lymph Nodes |
| **Allergic / Immunologic** | ☐ Frequent Colds/Flu ☐ Problems with Immunizations |
| **Psychiatric** | ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Confusion ☐ Suicidal Thoughts |

# Central Texas Colon and Rectal Surgeons

For your visit, please be prepared to:

- Provide photo ID, insurance card, referral information, and to complete and sign all patient forms.
- Pay your copay. *Payment is required at time of service.*
- Have your referring physician provide any prior test results and office visit notes relating to your appointment.

## PAYMENT/BILLING INFORMATION

Procedures and diagnostic exams done in the office may be categorized under your surgical benefits which can result in charges being applied to your annual deductible and not covered under your office visit co-pay.

The office will file insurance claims for services rendered to health plans we are contracted with, but patients are not relieved of responsibility for payment because of insurance coverage. Insurance Companies offer numerous plans and it is extremely difficult to determine prior to filing the claim how your benefits will be applied. We recommend reviewing your benefit plan and/or contacting your Insurance Company.

## MEDICARE PATIENTS additional information

The doctors accept assignment. Medicare pays 80% of covered charges after your annual deductible is met. The patient is responsible for the other 20%. We will file a claim for secondary insurance if the information is provided at the time your visit.

In addition, the initial consult/visit is not covered for screening and history of diagnosis. Please consult Medicare if you have any questions about your coverage for well-visits with no symptoms.

## PRIVATE PAY

Payment arrangements can be made prior to your appointment. This office offers a prompt pay discount when charges are paid at the time of service; no claim filing is required and this is not in violation of contractual agreements with insurance carriers.

## INSURED PATIENTS

The following are examples of services and codes which may be helpful when contacting your insurance company to determine if services will be covered under annual deductible or office visit co-payment:

- **In Office**: Anoscopy (diagnostic rectal exam) CPT code 46600; Sigmoidoscopy (diagnostic colon exam) CPT code 45330; Hemorrhoid excision (office procedure/surgery) CPT code 46221.
- **Screening Colonoscopy for colon cancer**, Diagnosis code Z12.11, is used when there are no symptoms present or found. A different diagnosis code must be used if there is a personal history, symptomatic diagnosis (i.e. blood in the stool) or any other diagnosis is found (i.e.polyp). These may have different insurance benefits. A modifier is added to the procedure code to let the insurance company know this was a “screening” colonoscopy.
  **Diagnostic Colonoscopy CPT code 45378:** This procedure code is used for reporting both screening and symptomatic colonoscopies. If polyps are removed or biopsies taken other coding is used, an example would be 45380 (colonoscopy with biopsy, single or multiple).
- Colonoscopies are performed in an outpatient setting, (Hospital or Surgery Center), not in our office. You will be billed separately by the facility.

*For additional information on payment or billing, please contact our Billing Office at 512-418-1979, option 6.*

***I have read and understand the above information.***

Patient/Responsible Party Signature _____ Date _____

***I have received the Notice of Privacy Practices and understand that I may receive a copy of this information upon request.***

Patient/Responsible Party Signature _____ Date _____