

NEW REGISTRATION

UPDATED REGISTRATION

McConnell Colorectal Center

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY NO.	
HOME ADDRESS			CITY	STATE	ZIP	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HOME PHONE	WORK PHONE	CELL PHONE			MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	
SPOUSE NAME					SPOUSE DOB:	
REFERRING PHYSICIAN NAME AND ADDRESS					REFERRING PHYSICIAN PHONE	

RESPONSIBLE PARTY INFORMATION

NAME	LAST	FIRST	MI	HOME PHONE	
ADDRESS		CITY	STATE	ZIP	SOCIAL SECURITY NO.
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

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:	
PATIENT'S SCHOOL ADDRESS IF STUDENT		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> SELF EMPLOYED	
CITY	STATE	ZIP	<input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT PERSON OTHER THAN SPOUSE				RELATIONSHIP
ADDRESS	CITY	STATE	ZIP	PHONE

INSURANCE INFORMATION & SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE		CARDHOLDER NAME AND SOCIAL SECURITY			DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER			
ADDRESS		CITY	STATE	ZIP	PHONE
SECONDARY INSURANCE		CARDHOLDER NAME AND SOCIAL SECURITY NO.			DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER			
ADDRESS		CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
 I hereby authorize direct payment to McConnell Colorectal Center of any medical benefits payable to me for the services provided at McConnell Colorectal Center. 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 my appointment. I will be responsible for the unpaid balance due for 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 _____

INFORMATION CONFIRMED BY STAFF: _____ **INSURANCE CARD SCANNED:** _____

Elizabeth J. McConnell, M.D. F.A.C.S.
McConnell Colorectal Center

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND
WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HEREIN WILL NOT
BE RELEASED TO ANYONE WITHOUT A SIGNED AUTHORIZATION FROM YOU.

Today's date: _____ Patient's name: _____

DOB: ____ / ____ / ____ / Age: ____ Height: ____ Weight: ____

Primary care physician: _____ (MD/DO/PA/NP)

Referral physician: _____ (MD/DO/PA/NP)

1. Why are you being referred to us?

2. Are you currently having any of the following symptoms?

Change in bowel patterns: Blood in stool Dark stool Diarrhea Constipation

Other symptoms:

- | | |
|---|---|
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Anal itching/burning/irritation |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Rectal drainage | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Pain with bowel movements | <input type="checkbox"/> Mass palpable with wiping |
| <input type="checkbox"/> Incontinence: <input type="checkbox"/> gas/stool/urine | <input type="checkbox"/> History of colon polyps |
| <input type="checkbox"/> liquid or mucus | <input type="checkbox"/> Family history of colon cancer. Age of dx: _____ |

Date of last sigmoidoscopy: _____ Date of last colonoscopy: _____

3. Medical history:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anal warts/hpv | <input type="checkbox"/> Herpes/hsv | <input type="checkbox"/> Viral exposure |
| <input type="checkbox"/> Other: _____ | | |

4. Surgical history:

PROCEDURE	DATE	HOSPITAL	SURGEON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's name: _____

5. Medications:

NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Medication allergies: Yes No If yes, which meds: _____

7. Smoking status: Yes No If yes, how much: _____

8. Illicit/recreational drug use: Yes No If yes which drug: _____

9. Are you on anticoagulant therapy/medication? _____

Other pertinent history, physicians notes:	
yo	CC:
FM Hx:	Colonoscopy:
PM Hx:	
PS Hx:	
Meds:	
All:	
Physician only to write below this line.	

BP: _____ Time: _____ Initials: _____
P: _____ In: _____ / Out: _____
Ht: _____ In: _____ / Out: _____
Wt: _____ In: _____ / Out: _____

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Pre-Op Checklist at Time of Scheduling

(Please complete all sections of this form)

Patient Name: _____

Do you have a history of any of the following? Please explain any items checked Yes.

Cardiovascular problems:

- Heart attack: Yes No _____
Heart failure: Yes No _____
Valve problems: Yes No _____
Abnormal heart rhythm: Yes No _____
Pacemaker/defibrillator: Yes No _____
Heart medications: Yes No _____
Poor circulation to legs: Yes No _____

Neurological problems:

- Stroke or TIA: Yes No _____
Spinal cord injury or problems: Yes No _____
Chronic muscle weakness: Yes No _____

Pulmonary problems:

- Emphysema/chronic bronchitis: Yes No _____
Smoking: Yes No _____
Asthma: Yes No _____
Use of oxygen at home: Yes No _____

Other health problems:

- Diabetes: Yes No Controlled by insulin? Pills? Diet?
Sleep apnea: Yes No _____
Cirrhosis of the liver: Yes No _____
Kidney disease or dialysis: Yes No _____
Other significant problems: Yes No _____
(If so, please list) _____

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Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

My Authorization:

You may use or disclose the following health care information: (check all that apply)

- All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted:

- My health information relating to the following treatment or condition:

- My health information for the date(s): _____

- All psychotherapy notes unless specifically excepted:

To:

You may disclose my healthcare information to:

Name:	Name:	Elizabeth J. McConnell, M.D.
		Colon & Rectal Surgery
Address:	Address:	6245 N 16th Street
City, State, Zip:	City, State, Zip:	Phoenix, AZ 85016

Reason(s) for this authorization (check all that apply):

- At my request: _____
- Other: (specify) _____

This authorization ends: on (date) _____

When the following event occurs _____

Signature: _____ Date: _____

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Acknowledgment 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 if signed on behalf of the patient

Relationship (parent, legal guardian,
personal representative, etc.)

You have my permission to leave detailed phone messages at the following phone #: _____

You have my permission to discuss my medical care with the following persons:

Name: _____

Birth date: _____

Phone: _____

Signature: _____