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PLEASE COMPLETE ALL FORMS BEFORE YOUR APPOINTMENT TO ENSURE THAT YOU ARE SEEN IN A TIMELY MANNER. PLEASE BRING PHOTO IDENTIFICATION, INSURANCE CARDS AND CURRENT MEDICATION LIST.

Dear Patient:

Enclosed you will find information regarding your appointment with Columbia Surgical Associates. **Please note: this is an office consultation visit only; no major surgery will be performed at this visit although minor diagnostic procedures may be performed (i.e. anoscopy, biopsy or an ultrasound). Your insurance co-pay will be due at the time of service. You can make payments by cash, check, money order, MasterCard, Visa, and Discover.**

Please bring the completed two sided forms with you to your appointment and arrive 15 to 30 minutes prior to your appointment time so that we may get your insurance information scanned into our system. The map to our location is on the back of this letter.

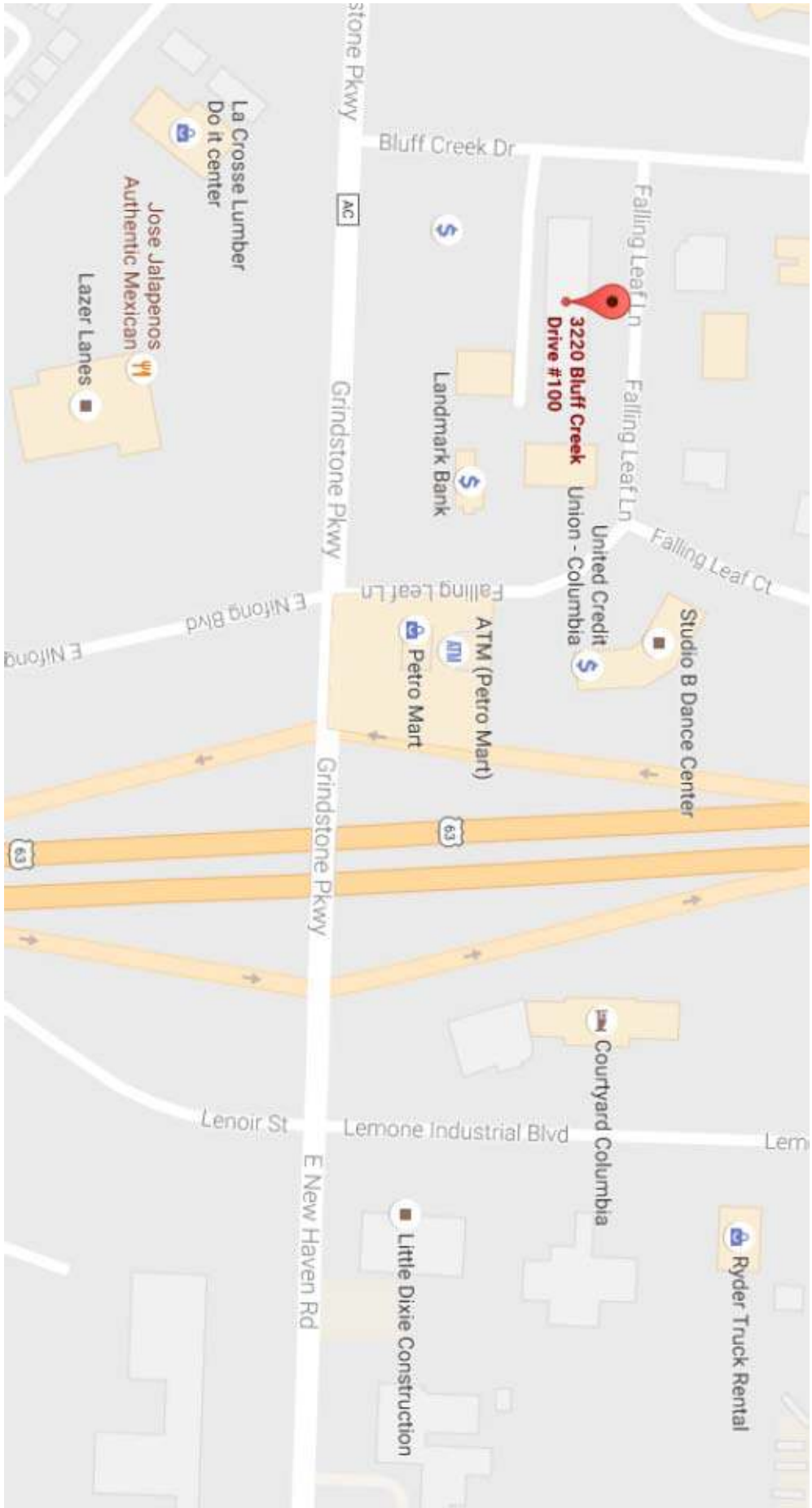
For elective surgeries (including, but not limited to gallbladder, and hernia surgery) our business office might contact your insurance company to determine your deductible and /or co-insurance which may be payable prior to the date of surgery.

Your insurance company may require a referral form from your primary care physician (listed on your insurance card) so it is important that you contact their office prior to your appointment. This will assure that your visit with us will be covered by your health insurance plan. **Also, if you have had any recent x-rays (including mammograms), lab work, EKG's or any tests that pertain to the problem you are being seen for,** please bring them with you to your appointment.

If you are unable to keep your appointment, please notify us 24 hours prior to the scheduled time. We will make every effort to change the appointment to a more acceptable time.

If you have any questions about your appointment, feel free to call our office Monday through Friday, 8:00 a.m. to 5:00 p.m.

Sincerely,
Physicians and Staff
Columbia Surgical Associates



Patient Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Sex:** Male Female

Social Security # _____ **Marital Status:** Single Married Divorced Widowed

Ethnicity: Non-Hispanic Hispanic

Race: White African American Asian Pacific Islander American Indian Unknown Decline to Say

Preferred Language: English Spanish Other: _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Communication Preference: Home Phone Cell Phone Mail Email

Employer: _____ **Work Phone:** _____ **EXT:** _____

Which Doctor Are You Seeing Today? _____

Referring Doctor 1: _____ **Phone:** _____

Referring Doctor 2: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Insurance Information

Primary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

Secondary Insurance Company: _____

Name of Insured: _____ **DOB:** _____

I.D. # _____ **Group #:** _____ **SS #:** _____

Effective Date of Coverage: _____ **Relationship to Patient:** _____

Employer: _____

Patient Authorization

Patient Signature

Date

(Power of Attorney or Authorized Signature if Minor)

I understand that I am responsible for my payment of services to Columbia Surgical Associates, I authorize the release of any and all medical records information necessary to process claims and requests for payment from my Insurance Company in compliance with HIPAA regulations. Further, I understand that certain procedures may not be covered by my insurance company and, in such situations I understand I will be responsible for payment for such services.

Workers Compensation/Auto Accident Liability Information

- Is your visit today related to a work injury? Yes No
 Is your visit today related to an auto accident? Yes No
 Is your visit today related to any other liability claim? Yes No

If you have answered "NO" to all of the questions above, please sign below:

Patient Signature: _____ Date: _____

If you answered "YES" to any of the questions above, please complete the rest of this form and sign below:

Do you have authorization from the insurance carrier for today's visit: Yes No

Has this claim been filed with the Missouri State Department of Workers Compensation:
 Yes No

If "YES" please provide the Report of Injury Number: _____

I authorize Columbia Surgical Associates, Inc. and/or its representatives to release my medical records information and/or discuss continued treatment of care with the designated insurance company or Workers Compensation carrier or its representatives as necessary to process claims and requests for payment.

Patient Signature: _____ Date: _____

HIPAA Authorization

I have been informed by Columbia Surgical Associates that the "Notice of Information Practices" is available in the waiting room for review. I understand that I have the right to ask question in order to seek clarification and/or request a copy of this document. Any medical or billing may be discussed with the following.

<input type="checkbox"/>	No information to be released to anyone
<input type="checkbox"/>	No information to be released without password
<input type="checkbox"/>	Release information to see contact grid
<input type="checkbox"/>	Patient unable to address at this time

Information Release Password

Patient Contacts	Release of Medical Info/PHI	Relationship	Primary Phone	Alternative Phone

Patient Signature: _____ Date: _____

Place Patient Sticker Here

Patient Name: _____ Date of Birth: _____

History of Present Illness

Reason for today's visit: _____

What makes this better or worse: _____

Date illness started: _____ Severity of pain 1-10 (10 being worst): _____

Quality of pain (stabbing/pressure-like/etc.): _____

Vitals (Will be completed by nursing staff)

Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____

Surgical History

Please list all surgeries:

Surgery	Year	Complications/Details
Colonoscopy		
Prostate Surgery		
Hernia		
Gall Bladder		
Appendectomy (Appendix)		
Hysterectomy w/ or w/o Removal of Ovaries		
Heart Catheterization		
Heart Bypass		
Any Vascular Surgeries (Please Explain)		
Breast		
Thyroid		
Other:		
Other:		

Please list all Hospitalizations:

Hospitalization Reason	Date	Hospital

Preferred Learning Style(s):

<input type="checkbox"/> Computer if available	<input type="checkbox"/> Discussion	<input type="checkbox"/> TV/Video if available
<input type="checkbox"/> Demonstration	<input type="checkbox"/> Reading material/handouts	<input type="checkbox"/> Other: _____

For Women Only

Do you think you may be currently pregnant: Yes No

How many times have you been pregnant: _____

What age were you at your first pregnancy: _____

How many children do you have: _____

What age did you start having periods: _____

Are you still having regular menstrual cycles: Yes No

Are you now on or have you ever been on Hormone Replacement Therapy: Yes No

Have you had a mammogram: Yes No

If **YES**, When: _____ Results: Normal Abnormal

Social History

Who lives in your home: _____

Are you currently working: Yes No

Reason (if **No**) Unemployed Retired Disabled Other: _____

Your Occupation: _____ Full-Time Part-Time Student

Do you smoke: No/Never Former/Quit-Date: _____

Yes, I am interested in quitting. **Yes**, Not interested in quitting

Packs Per Day: _____

Do you use other tobacco products: No/Never Former/Quit-Date: _____

Yes, I am interested about quitting. **Yes**, Not interested in quitting

Amount Per Day: _____

Do you Drink Alcohol: Yes No

If **YES**, How Often: Rarely (1-2 a year) Daily Weekly (1-2) Monthly (1-2)

Yes, I am interested in quitting. **Yes**, Not interested in quitting

Do you drink more than 6 cups of caffeinated beverages per day: Yes No

Patient Name: _____ **Date of Birth:** _____

Family Medical History

Please check "Yes" and list the relation if any family members suffer from any of the conditions below. Check "No" if no family members suffer from any of the listed conditions.

Family Member		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer - Uterine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer - Ovarian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colon/Rectal Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Malignant Hyperthermia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with Anesthesia: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PVD (Peripheral Vascular Disease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcerative Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The above information is completed to the best of my knowledge

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Do you now or have you recently had any problems related to the following systems? Check Y (Yes) or N (No). If you mark Yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Review of Systems

<u>Cardiovascular:</u>			<u>Hematological/Lymphatic:</u>			<u>Respiratory:</u>		
Chest Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Persistent Enlarged Glands	<input type="checkbox"/> Y	<input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Palpitations	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood Clotting Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Frequent Cough	<input type="checkbox"/> Y	<input type="checkbox"/> N
Murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bleeding Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Chronic Cough	<input type="checkbox"/> Y	<input type="checkbox"/> N
Leg Swelling	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Musculoskeletal:</u>			Shortness of Breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Irregular Heartbeat	<input type="checkbox"/> Y	<input type="checkbox"/> N	Joint Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Gastrointestinal:</u>		
<u>Constitutional Symptoms:</u>			Neck Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Abdominal Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	Back Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nausea	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chills	<input type="checkbox"/> Y	<input type="checkbox"/> N	Assistive Devices	<input type="checkbox"/> Y	<input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weight Loss	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Neurological:</u>			Intolerance to Greasy Foods	<input type="checkbox"/> Y	<input type="checkbox"/> N
Weight Gain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Headache	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood in Stool	<input type="checkbox"/> Y	<input type="checkbox"/> N
<u>Endocrine:</u>			Seizures	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N
Excessive Thirst	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tremors	<input type="checkbox"/> Y	<input type="checkbox"/> N	Incontinence of Stool	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hot/Cold Intolerant	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dizzy Spells/Fainting	<input type="checkbox"/> Y	<input type="checkbox"/> N	Difficulty Swallowing	<input type="checkbox"/> Y	<input type="checkbox"/> N
Tired	<input type="checkbox"/> Y	<input type="checkbox"/> N	Numbness/Tingling	<input type="checkbox"/> Y	<input type="checkbox"/> N	Reflux/Heartburn Indigestion	<input type="checkbox"/> Y	<input type="checkbox"/> N
<u>Genitourinary:</u>			Weakness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Colon/Rectal Polyps	<input type="checkbox"/> Y	<input type="checkbox"/> N
Urine Retention	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Skin:</u>			<u>Psychological:</u>		
Painful Urination	<input type="checkbox"/> Y	<input type="checkbox"/> N	Changes in hair or nails	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you feel Anxious/Nervous	<input type="checkbox"/> Y	<input type="checkbox"/> N
Urinary Frequency	<input type="checkbox"/> Y	<input type="checkbox"/> N	Change in skin color	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Difficulty Urinating	<input type="checkbox"/> Y	<input type="checkbox"/> N	Itching	<input type="checkbox"/> Y	<input type="checkbox"/> N	<u>Allergic and Immune:</u>		
Incontinence	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rash	<input type="checkbox"/> Y	<input type="checkbox"/> N	Allergic reaction to medication or x-ray dye	<input type="checkbox"/> Y	<input type="checkbox"/> N
<u>Eyes:</u>			<u>Ear, Nose, Mouth and Throat</u>					
Blurred vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Loss of sense of smell	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Double vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hearing loss	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Loss of vision	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ring in your ears	<input type="checkbox"/> Y	<input type="checkbox"/> N			
<u>Other:</u>								

Advanced Directive

Do you have an advanced directive? Yes No

If **No**, would you like information about setting up one? Yes No

If **Yes**, will you provide a copy for your medical record? Yes No

Personal Medical History

Please Check "Yes" for any medical conditions YOU suffer from and check "No" if you do not suffer from the condition

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hiatal Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Atrial Fibrillation /Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(Had a) Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Colon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignant Hyperthermia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer – Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cirrhosis of the Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colon/Rectal Polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PVD Peripheral Vascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers – Leg	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers - Stomach	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Freq. Headache/Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Renal Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea - CPAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep apnea - BiPAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any major or chronic illnesses not listed above:

None
