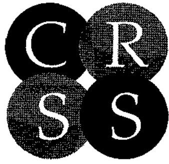

COLON & RECTAL SURGICAL SPECIALISTS OF NEW YORK

www.CRSSNY.com

Dean Pappas, M.D., FACS, FASCRS
Jules Garbus, M.D., FACS, FASCRS
Steven Pelaez, M.D., FACS
Mala Murthy Balakumar, M.D., FACS

PATIENT REGISTRATION

Who are you seeing today? Dr. Dean Pappas/Dr. Jules Garbus/Dr. Steven Pelaez/Dr. Mala Balakumar

Last Name:____________________ First:____________________ MI:______

Address:____________________ City:______________ State:_____ Zip:_____

Home#:_____-_____-_____ Cell#:_____-_____-_____ Work#:_____-_____-_____

What is your Date of Birth:_____/_____/_____ Age:__________

Circle One: Male/Female Marital Status: Single/Married/Divorced/Separated/ Widowed

What is your current Height:________ Weight:________

Social Security#:_____-_____-_____

What is your Email Address?

____________________@____________________

Who is your Family or Primary Care Physician?

Name:____

Address:______________________________ Phone:#:_____-_____-_____

Who may we thank for this referral?
Doctor/Friend/Family/Insurance Company/Internet/Other

If a Physician, Who is the referring Physician?

Name:________________________ Phone#:_____-_____-_____

Address:____

Emergency Contact Information:

Name:______________________________ Phone#:_____-_____-_____

Address:____

What is your relationship to the above person?________________________

1100 Franklin Avenue, Suite 203
Garden City, NY 11530
Tel: (516) 248-2422 | Fax: (516) 248-5162

226 N. Belle Mead Road
East Setauket, NY 11733
Tel: (631) 675-0568 | Fax: (516) 520-1125

Name:______________________________

Insurance Information

Primary Insurance Company:_________________________Policy#:_____________________

If insurance is under your spouse/parent for billing purposes, please provide:

Name:______________________Date of Birth:_____/_____/_____SS#:_____/_____/_____

Secondary Insurance Co. Name:_____________________Policy#:______________________

If under spouse/parent:_________________Date of Birth:___/___/____SS#:____/___/____

Third Insurance Co. Name:___________________________Policy#:______________________

If under spouse/parent:_________________Date of Birth:___/___/____SS#:____/___/____

What is your Pharmacy Information?

Name:____Phone#:_____-_____-_____

Address:____

MEANINGFUL USE REQUIREMENT(government mandated):

Please Circle One:

Race: White, Hispanic, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic/Non-Hispanic Preferred Language:________________

Social History-Please Check ALL that apply:

Smoking Status: ( ) Never ( ) Former- When did you quit:_______

( )Current daily smoker – How many packs:_______

( )Current sometime smoker-Explain:_____________________

Privacy Practices Acknowledgement:

I have Read/Received the notice of privacy practice and I have been provided an opportunity to review it. Due to the HIPPA Law we are Not Allowed by Law to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

INSURANCE ASSIGNMENT AND RELEASE:

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours. By law, we much collect your carrier designated copay, deductible and co-insurance. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a $10 charge will be added to your account. If there are reasons you cannot make your copay at each visit, arrangements MUST be made and approved in advance. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature:___________________________________ **Date:**_____/_____/_____

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Date: ______________

Name: ______________________________

Date of Birth: _________________________

Chief Complaint: ____________________________________

How long have you had this complaint? ______________________________

History of Present Illness: ____________________________________
____
____
____

How often do you have a bowel movement? ___________________

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright	Dark
If yes, is the blood mixed with the stool or not mixed with the stool?	Yes	No
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No
Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No
Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
If you have given birth, did you have birthing trauma requiring stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No

If yes, what is the location? ______________________________

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Date: ____________

Name: __________________________

Date of Birth: __________________

Do you have a personal history of colon or rectal cancer?	Yes	No
Do you have a personal history of colitis?	Yes	No
Do you have a personal history of colon or rectal polyps?	Yes	No
Do you have a family history of colon or rectal cancer?	Yes	No
Do you have a family history of colonic polyps?	Yes	No

Have you ever had a colonoscopy?
If yes, date and results: ______________________________

Current Medications: (Please include name and dosage. Include over-the-counter, herbal and natural)

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

Do you need antibiotics prior to dental procedures? Yes No

Past Medical History (please check any medical problems that you have had in the past):

__Anemia	__Depression	__Kidney stones
__Anticoagulation Therapy	__Diabetes	__Liver disease
__Anxiety	__Fatty liver	__MI (heart attack)
__Arthritis	__Fibromyalgia	__Osteoporosis
__Cancer	__GERD (heartburn)	__Pancreatitis
__Cataracts	__Heart disease or pacemaker	__Primary biliary cirrhosis
__Chronic lung disease	__Hepatitis B	__Primary sclerosing cholangitis
__Cirrhosis	__Hepatitis C	__Rashes/skin problem
__Colonic polyps	__High cholesterol	__Renal insufficiency
__Congestive heart failure	__High blood pressure	__Sleep apnea
__Coronary artery disease	__Inflammatory bowel disease	__Thyroid disease
__Crohn's disease	__Irritable bowel syndrome	__Ulcerative colitis
__Deep vein thrombosis	__Kidney disease	__Other (specify)__________

Females only, # of pregnancies ______ # of deliveries ______

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Date: ______________

Name: ______________________________

Date of Birth: _________________________

Allergies to Medications: (Please include name of medication and reaction)

______________________ ______________________
______________________ ______________________

Other Allergies:

______________________ ______________________
______________________ ______________________

Past Surgical History: (Please list any surgeries and approximate year)

______________________ ______________________
______________________ ______________________
______________________ ______________________

Were you ever hospitalized? (for any reason other than the above surgeries)
If yes, please list reason and approximate date.

______________________ ______________________
______________________ ______________________

Family History: (Please check below to report problems your family members might have had and the family members with the problem, e.g. "father with colon cancer"

______________________ ______________________
______________________ ______________________
______________________ ______________________

Social History:
Do you smoke? If yes, how much? ____________________
Do you drink alcohol? If yes, how much? ________________

Height: _________ Weight: _________