

ARIZONA ASSOCIATED SURGEONS, PLLC

- | | | |
|--------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Charles E. Castillo, MD | <input type="checkbox"/> Richard J. Harding, MD | <input type="checkbox"/> Elizabeth J. McConnell, MD |
| <input type="checkbox"/> William R. Friese, MD | <input type="checkbox"/> David C. Johnson, MD | <input type="checkbox"/> Keith G. Zacher, MD |

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #
HOME ADDRESS			CITY	STATE	ZIP
			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
HOME PHONE #	WORK PHONE #	CELL PHONE #		MARRIED 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 #		
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 INFO - OTHER THAN SPOUSE	RELATIONSHIP
ADDRESS	PHONE
CITY	
STATE	
ZIP	

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	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 Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons.

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 appointment. I will be responsible for the unpaid balance due 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 Date

INFORMATION CONFIRMED BY STAFF: _____

INSURANCE CARD SCANNED: _____

Elizabeth J. McConnell, MD. FACS.
Colon & Rectal Surgery

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTROY 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 FOLLOWIN SYMPTOMS?:

CHANGE IN BOWEL PATTERNS

BLOOD IN STOOL _____ DARK STOOL _____
 DIARRHEA _____ CONSTIPATION _____

OTHER SYMPTOMS

RECTAL BLEEDING _____	ANAL ITCHING/BURNING/IRRITATION _____
RECTAL PAIN _____	ABDOMINAL PAIN _____
RECTAL DRAINAGE _____	HEMORRHOIDS _____
PAIN WITH BOWEL MOVMEMNTS _____	MASS PALPABLE WITH WIPING _____
INCONTINENCE GAS/STOOL/URINE _____	HX OF COLON POLYPS _____
LIQUID OR MUCUS _____	FAMILY HX COLON CANCER _____
	AGE OF DX _____

DATE OF LAST SIGMOIDOSCOPY _____ DATE OF LAST COLONOSCOPY _____

3. MEDICAL HISTORY:

HYPERTENSION _____	DIABETES _____	ASTHMA _____
SEIZURES _____	HEART DISEASE _____	STROKE _____
CANCER _____	LIVER DISEASE _____	HEPATITIS _____
BLEEDING DISORDER _____	THYROID DISEASE _____	HIV _____
ANAL WARTS/HPV _____	HERPES/HSV _____	VIRAL EXPOSURE _____
OTHER _____		

4. SURGICAL HISTORY:

<u>PROCEDURE</u>	<u>DATE</u>	<u>HOSPITAL</u>	<u>SURGEON</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT'S NAME: _____

5. MEDICATIONS:

<u>NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

<u>Other pertinent history, Physicians Notes:</u>	
yo	CC:
FMHx:	Colonoscopy:
PMHx:	
PSHx:	
Meds:	
All:	
Physician only to write below this line.	

BP:
P:
Ht:
Wt:

	<u>Time:</u>	<u>Initials:</u>
In: _____	/ Out: _____	_____
In: _____	/ Out: _____	_____
In: _____	/ Out: _____	_____

PRE-OP CHECKLIST AT TIME OF SCHEDULING
(Please complete all sections of the form)

Patient Name

Do you have a history of?

CARDIAC:

- 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:

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

PULMONARY:

- Emphysema/chronic bronchitis? Yes No _____
- Smoking? Yes No How much? _____ How long? _____
- Asthma? Yes No _____
- Use of oxygen at home? Yes No _____

GENERAL:

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

Elizabeth J McConnell, M.D.

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 MD
COLON & RECTAL SURGERY
333 E VIRGINIA STE 110
PHOENIX AZ 85004

Address: _____

Address: _____

City, State, Zip _____

City, State, Zip _____

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: _____

Elizabeth J. McConnell, MD, PLC

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: _____