East TN Colon & Rectal Surgical Associates, P.C.

James W. Baker, M.D.,F.A.C.S.

Jay A. Young, M.D.,F.A.C.S.

Patient Information

Full Legal Name________________________________ Date of Service______________________

Address________________________________ City______________ State_____ ZIP________

Home Phone(___) ______________________________ Cell Phone(___)______________________

Date of Birth________________ Age________ Social Security Number______________________

Marital Status: Married, Single, Widowed, Divorced Sex: Male or Female

Employer________________________________ Work Phone(___)______________________

If retired , former occupation__________________ If Disabled, from what__________________

Insurance Information

Primary Insurance________________________________ ID#______________________

Is the above coverage through:

A. Your employer B. Your Retirement Plan C. Your spouse or family member's employer D. Other____________

Secondary Insurance________________________________ ID#______________________

Is the above coverage through:

A. Your employer B. Your Retirement Plan C. Your spouse or family member's employer D. Other____________

Spouse or Family Member's Name________________________ Relationship______________

Social Security Number________________________________ Date of Birth______________

ER Contact

Emergency Contact Information____

Phone #________________________________ Relationship________________________

Complaint

Reason for coming to office today or complaints________________________________

Family Physician________________________ Address________________________________

Who referred you to our practice? ________________________________

Is this a Physician, Family Member, Friend, or Other Source: Phone Book, ER, Internet.

Medications, Allergies, and Conditions

List Current Medications with dosage and how often you take them.

(name)	(dosage)	(how often)	(name)	(dosage)	(how often)
1.			2.		
3.			4.		
5.			6.		

List allergies to medicines____

Are You allergic to Latex, Iodine, or X-ray Dye________________________________

Have you ever had a colonoscopy? Yes or No When was most recent? ____________________

Circle Yes or No if you have had any of the following:

Condition			Condition		
High Blood Pressure	Y N	____________	Diabetes	Y N	____________
Heart Trouble	Y N	____________	Stoke	Y N	____________
Bleeding Problems	Y N	____________	HIV/AIDS	Y N	____________
Kidney Disorders	Y N	____________	Heart Murmur	Y N	____________
Colon Disorders	Y N	____________	Cancer	Y N	____________
Other Illnesses	Y N	____________			

DATE OF SERVICE:__________________ NAME:______________________________

PLEASE LIST PAST SURGERIES, HOSPITALIZATIONS OR INJURIES:

Operations/Illness	Date	Physician/Hospital

CHILDBIRTH INFORMATION:

List dates and types of delivery: (vaginal delivery or c-section) ______________________

____

FAMILY HISTORY:

Please list any medical problems in your relatives:

Father______________________ Mother______________________

Siblings____

Children____

SOCIAL HISTORY:

Tobacco Use ☐ Never ☐ Quit/when_______ ☐ Current / packs per day ______________

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily How much? ______________

Drug Use ☐ Never ☐ Past History/ Quit when? Type? ______________ ☐ Current Drug User

How often do you have a bowel movement ? ______________________________

Do you use laxatives ? Y N How often/What kind ? ______________________________

REVIEW OF SYSTEMS: Please circle:

☐ Constitutional
- Good General Health Y N
- Recent weight change Y N
- Night sweats, fevers Y N
- Fatigue/Weakness Y N

☐ ENT
- Hearing loss or ringing Y N
- Sinus problems Y N
- Nose bleeds Y N
- Sore throat Y N

☐ Eyes
- Wear glasses/contacts Y N
- Blurred/Double vision Y N
- Eye disease or injury Y N
- Glaucoma Y N

☐ Cardiovascular
- Chest pain Y N
- Palpitations Y N
- Heart trouble Y N
- Swelling hands/feet Y N

☐ Respiratory
- Shortness of breath Y N
- Cough Y N
- Wheezing/Asthma Y N
- Coughing up blood Y N

☐ Musculoskeletal
- Muscle pain or cramps Y N
- Stiffness/swelling joints Y N
- Joint Pain Y N
- Trouble walking Y N

☐ Neurological
- Frequent headache Y N
- Paralysis or tremors Y N
- Convulsions/seizures Y N
- Numbness/tingling Y N

☐ Integumentary (Skin/Breast)
- Change in hair or nails Y N
- Rashes or itching Y N
- Breast lump Y N
- Breast pain/discharge Y N

☐ Endocrine
- Excessive thirst/urination Y N
- Thyroid disease Y N
- Hormone problem Y N

☐ Hematologic/Lymphatic
- Bruise easily Y N
- Slow to heal Y N
- Enlarged glands Y N

☐ Psychiatric
- Insomnia Y N
- Confusion/memory loss Y N
- Depression Y N

☐ Genitourinary
- Blood in Urine Y N
- Kidney stones Y N
- Testicle pain Y N
- Menstrual pain Y N

☐ Gastrointestinal

Nausea/vomiting	Y N	How long? ____________
Abdominal Pain	Y N	How long? ____________
Pain w/ bowel movement	Y N	How long? ____________
Unable to control gas	Y N	How long? ____________
Unable to control BM	Y N	How long? ____________
Constipation/diarrhea	Y N	How long? ____________
Diarrhea	Y N	How long? ____________
Awakened by rectal pain	Y N	How long? ____________
Rectal burning	Y N	How long? ____________
Rectal bleeding	Y N	How long? ____________

- **To the best of my knowledge, this information is correct and accurate. I authorize the release of medical information necessary to process my insurance claims. I authorize payment of insurance benefits to the Physician.**

SIGNED X ______________________

I have reviewed with patient:

____________MD

EAST TENNESSEE COLON & RECTAL SURGICAL ASSOCIATES

PLEASE READ

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore you are responsible for the balance.

FINANCIAL RESPONSIBILITY

I understand if I have not secured the appropriate referrals and authorizations and otherwise followed the terms of my health plan benefits, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive, and that I will be financially responsible for the services not covered, including co-payments, co-insurance and deductibles. If I have no insurance, I understand that I will be financially responsible for all services provided.

Patient or Guardian's Signature ____

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits (including Medicare, and any other government sponsored program, private insurance, and any other health plans) be made to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **East Tennessee Colon & Rectal Surgical Associates, P.C.** to act as my agent to help me obtain any required precertification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give **East Tennessee Colon & Rectal Surgical Associates, P.C.** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature ______________________________ Date ______________________

MEDICAL RECORDS RELEASE

I hereby authorize East Tennessee Colon & Rectal Surgical Associates, P.C. to release any information in my chart to any practitioner, doctor, hospital, medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital or medical institution to assist in my care.

Patient's Signature ______________________________ Date ______________________

OFFICE EXAMINATION

I Consent to have an examination by Dr. Baker or Dr. Young. This may include an anorectal exam, proctoscopy and/or flexible sigmoidoscopy. I understand that the Physician will discuss this with me including the possibility of pain, cramping, bleeding and the remote possibility of perforation, which would require surgery.

Patient's Signature ______________________________ Date ______________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of East TN Colon & Rectal Surgical Associates Notice of Privacy Practices. This Notice describes how East TN Colon & Rectal Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosures of my healthcare information, and rights I may have regarding my protected health information.

Patient's Signature ______________________________ Date ______________________

FOR MEDICARE SUPPLEMENT POLICIES ONLY

ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

I request that payment of authorized Medigap benefits be made on my behalf to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for services furnished me by them. I authorize any holder of medical information about me to release to

______________________________ (name of policy)

Any information needed to determine these benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's Signature ______________________________ Date ______________________

FORM 0002

EAST TENNESSEE COLON & RECTAL SURGICAL ASSOCIATES, P.C.
MAIN OFFICE:
10810 Parkside Drive
Suite G-12
Physicians Plaza
Knoxville, TN 37934

PERMISSION TO DISCLOSE PHI

East Tennessee Colon & Rectal Surgical Associates has my permission to:

____leave messages on my answering machine regarding my Protected Health Information. Yes No

____send reminder cards for appointments to my home address. Yes No

____speak with my family members or others listed below concerning my Protected Health Information. Yes No

____

____

____

____

If you do not want any information given to certain family members, please list them below.

____

____

____

____ ____________
Patient Signature **Date**

FORM 0003