Wisconsin
Colon & Rectal Clinic

Thank you for choosing Wisconsin Colon & Rectal Clinic for your healthcare needs. We look forward to meeting you. Please arrive at least 15 minutes prior to your appointment time to register for your visit.

To make your initial visit to our office more efficient, the patient registration forms necessary for your appointment are included with this letter. Please fill them out **prior** to your appointment and bring them with you on the day of your visit. **Incomplete forms will delay your scheduled appointment time.** In addition, please remember to bring the following:

- Your insurance card(s).
- Co-payment(s) may be required by your insurance plan. For your convenience, we accept cash, checks, Mastercard, Visa, and Discover cards.
- The name of the hospital of choice under your insurance plan.
- If your insurance plan requires a referral, please make arrangements with your primary care provider prior to your appointment. If a referral has not been received by the date of your appointment, the appointment may need to be rescheduled.
- Other _____

If you have any questions, please feel free to call us.

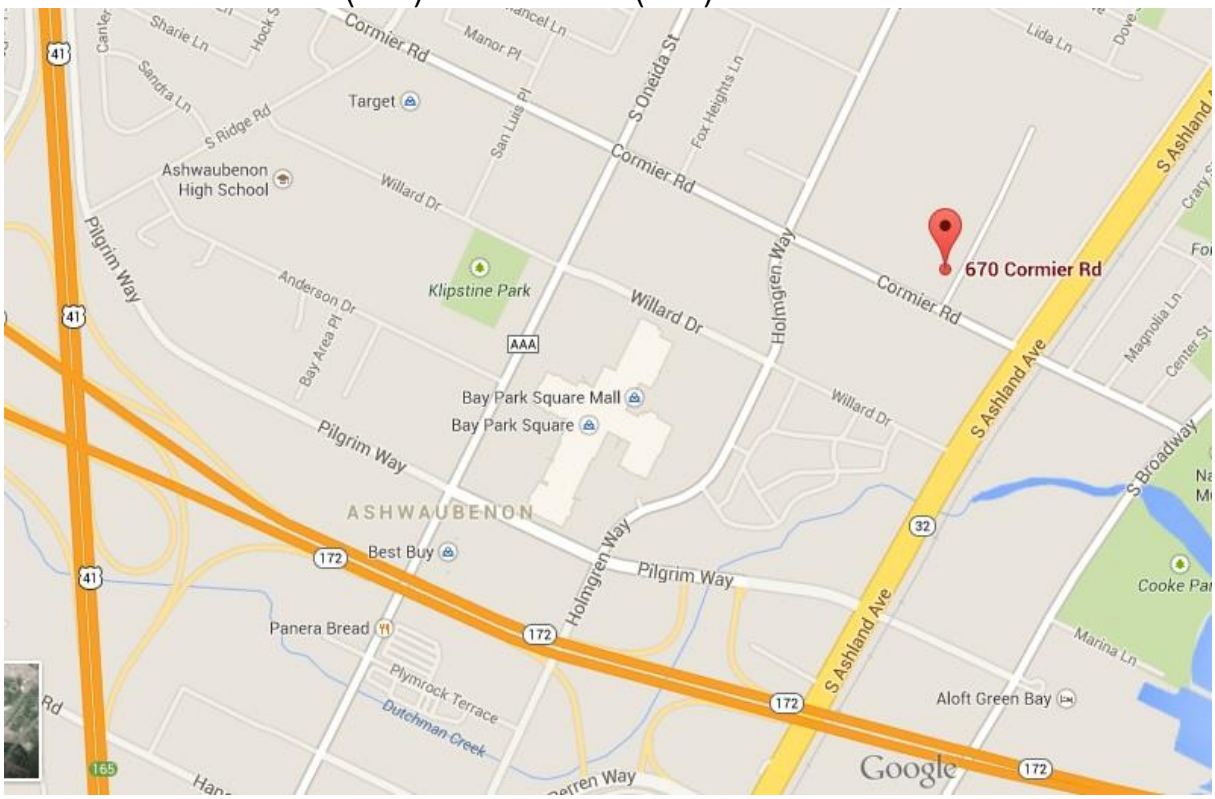
Sincerely,

The Staff of Wisconsin Colon & Rectal Clinic

Wisconsin Colon & Rectal Clinic

A Division of NEW Surgical Associates

670 Cormier Road
Green Bay, WI 54304
(920) 494-9685 or (800) 453-2682



From the East on Hwy. 172:

On Hwy. 172, take the Oneida St/Ashland Ave. Exit. Turn right on to Pilgrim Way. Turn left on Ashland Ave. Turn left on Cormier Rd. Our office is on the right hand side.

From the UP:

Take Hwy. 41 S. to the Lombardi Ave Exit, #167. Turn left on Lombardi Ave. Turn right on Oneida St. Turn left on Cormier Rd. Our office is on the left hand side.

From the Fox Valley:

Take Hwy. 41 N. to Green Bay. Take Oneida St/Waube Lane Exit, #164. Turn right on Oneida St. Turn right on Cormier Rd. Our office is on the left hand side.

From the West on Hwy. 172:

Take the Oneida St/Ashland Ave. Exit. Turn left on Vanderperren Way. Turn left on Ashland Ave. Turn left on Cormier Rd. Our office is on the right hand side.

Wisconsin Colon & Rectal Clinic

Green Bay Vein Center

NEW Surgical Associates Patient Registration

Full **Legal** Name _____ DOB _____/_____/_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partner SSN# _____-_____-_____

Street _____ Apt# _____ City _____ State ____ Zip _____

Employer _____ Email _____

Spouse's Name _____ Phone # (_____) _____ - _____

Emergency Contact (if not spouse) _____ Phone # (_____) _____ - _____.

If patient is a minor or has a legal guardian:

Name of Parent / Guardian _____ Phone # (_____) _____ - _____

Consent to Allow Access to Protected Health Information/Contact Permission: If we need to contact you for matters including but not limited to test results, appointment reminders, payment issues, coverage of services and benefit determination, we will attempt to reach you by the method you specify:

BEST FORM OF CONTACT: ☐ Home # ☐ Cell # ☐ Work # Best time to call _____

Home Ph# (_____) _____ - _____ May we identify ourselves and leave a message? □ Yes □ No

Cell Ph# (_____) _____ - _____ May we identify ourselves and leave a message? □ Yes □ No

Work Ph# (_____) _____ - _____ May we identify ourselves and leave a message? □ Yes □ No

INSURANCE INFORMATION

PRIMARY INSURANCE □ **None** Relationship to PATIENT □ Self □ Spouse □ Other_____

Insurance company name _____

Subscriber Name _____ Subscriber DOB _____/_____/_____

Policy ID # _____ Group # _____

SECONDARY INSURANCE □ **None** Relationship to PATIENT □ Self □ Spouse □ Other_____

Insurance company name _____

Subscriber Name _____ Subscriber DOB _____/_____/_____

Policy ID # _____ Group # _____

Wisconsin Colon & Rectal Clinic

Green Bay Vein Center

NEW Surgical Associates Patient Registration

Consent to Access of Protected Health Information: The following are family members or representatives to whom we may disclose your protected health information, such as, but not limited to, test results, appointment reminders, payment issues, benefit determination, and coverage of services. Please indicate any restrictions on the type of disclosures to be made to these representatives. You may revoke consent at any time by giving written notice.

Name _____ Phone # (_____) _____ - _____ Relationship_____

Any restrictions? _____

Name _____ Phone # (_____) _____ - _____ Relationship_____

Any restrictions? _____

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of NEW Surgical Associates Notice of Privacy Practices, which describes how NEW Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure, and rights I may have regarding my protected health information.

Initials _____

Consent to access Relay Health for Medication/Allergy Information: I hereby give NEW Surgical Associates permission to access RelayHealth (provides clinical connectivity to physicians, patient, hospitals and more using innovative health information technology) to import medication/allergy information. Initials _____

Billing Insurance: I understand my insurance is billed as a courtesy, and I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections on any amount owed for services rendered, I agree to pay for all expenses, including reasonable attorney fees. I authorize the release of information concerning my/my child's health care, advice & treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of surgical or medical benefits to NEW Surgical Associates.

Initials _____

Consent to Evaluation and Treatment: I agree and give consent for NEW Surgical Associates to furnish medical care and treatment considered necessary and proper in diagnosing or treating my medical condition. This includes but is not limited to examination, diagnostics, photographs, and requests for medical record information.

Signature of Patient or Representative: _____Date: ____/_____/_____

Patient Representative Relationship: _____

Patient Name: _____**DOB**: _____**Today's Date**: _____

Pharmacy:_____**Pharmacy Phone**:_____

Pharmacy Address:_____

Current Medications (prescription, over-the-counter, herbal, vitamins)	Dose/Strength	Frequency/ When Taken	Ordering Doctor	What It's Taken For

Allergies

Medication Allergies

Drug	Reaction

Environmental Allergies (food, tape, latex, etc.)

Drug	Reaction

Additional information: _____

Wisconsin Colon & Rectal Clinic

Name _____
Date of Birth _____

Past Medical History

Have you ever had any medical problems? ❑ Yes ❑ No

(If yes, please check the box in front of the condition.)

- ❑ Cataract
- ❑ Glaucoma
- ❑ Emphysema
- ❑ COPD
- ❑ Asthma
- ❑ Bronchitis
- ❑ Sleep apnea
- ❑ Pulmonary embolus (PE)
- ❑ Tuberculosis
- ❑ Respiratory failure
- ❑ Angina pectoris (chest pain)
- ❑ Congestive heart failure (CHF)
- ❑ MI (heart attack)
- ❑ Atrial fibrillation
- ❑ Arrhythmia
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ High cholesterol/lipids
- ❑ Diabetes
- ❑ DVT (clot in leg vein)
- ❑ Varicose veins
- ❑ Leg swelling/ulcers
- ❑ Stroke
- ❑ TIA (transient ischemic attack)
- ❑ GERD (Gastric reflux)
- ❑ Peptic ulcer
- ❑ Jaundice
- ❑ Fatty liver
- ❑ Pancreatitis
- ❑ Crohn's disease
- ❑ Ulcerative colitis
- ❑ Ischemic colitis
- ❑ IBS (Irritable bowel syndrome)
- ❑ Diverticulitis
- ❑ Hemorrhoids
- ❑ Urinary incontinence
- ❑ Prostate enlargement
- ❑ Prostatitis
- ❑ Kidney stones
- ❑ Kidney failure
- ❑ Urinary tract infection
- ❑ Polycystic ovarian syndrome
- ❑ Arthritis
- ❑ DJD (osteoarthritis)
- ❑ Herniated disc or other back problem
- ❑ Sciatica
- ❑ Fibromyalgia
- ❑ Scarlet fever
- ❑ Sexually transmitted disease
- ❑ HIV infection
- ❑ History of MRSA
- ❑ Previous blood transfusion
- ❑ Clotting disorder
- ❑ Anemia
- ❑ Cancer _____
- ❑ Hypothyroidism (underactive)
- ❑ Hyperthyroidism (overactive)
- ❑ Gout
- ❑ Seizures
- ❑ ADHD
- ❑ Drug dependence
- ❑ Phobia
- ❑ Eating disorder
- ❑ Bipolar disorder
- ❑ Psychoses
- ❑ Depression
- ❑ Other _____

Wisconsin
Colon & Rectal Clinic

Name _____
Date of Birth _____

Past Surgical History

Have you ever had any operations? ❑ Yes ❑ No

(If yes, please check the appropriate box or boxes below and specify the type of operation.)

- ❑ Eye operation _____
- ❑ Sinus operation _____
- ❑ Tonsillectomy _____
- ❑ Thyroid operation _____

- ❑ Breast biopsy _____
- ❑ Mastectomy _____

- ❑ Coronary stent placement _____
- ❑ Coronary artery bypass (CABG) _____
- ❑ Heart valve repair/replacement _____
- ❑ Abdominal aortic aneurysm repair _____
- ❑ Peripheral vascular operation (bypass of blood vessel in arm or leg) _____

- ❑ Esophagus operation _____
- ❑ Gastrointestinal operation (*e.g.* ulcer, small intestine, etc.) _____
- ❑ Colon operation _____
- ❑ Appendectomy _____
- ❑ Anal or rectal operation _____
- ❑ Gallbladder _____
- ❑ Pancreas operation _____

- ❑ Umbilical hernia repair _____
- ❑ Inguinal hernia repair _____
- ❑ Incisional hernia repair _____

- ❑ Dilatation and curettage _____
- ❑ Tubal ligation _____
- ❑ Cesarean section _____
- ❑ Uterine suspension _____
- ❑ Hysterectomy _____
- ❑ Bladder suspension _____
- ❑ Prostate operation _____

- ❑ Back operation _____
- ❑ Other orthopedic operation (*e.g.* fracture repair, knee scope, hip replacement, etc.) _____

- ❑ Other _____

Wisconsin Colon & Rectal Clinic

Name _____
Date of birth _____

Social and Family History

Social History

Employment status: ❑full-time ❑part-time ❑not employed ❑student ❑retired
❑disabled ❑occupation _____ ❑other _____

Tobacco use: ❑I do not use tobacco
❑current smoker *# packs?* ___ *# years?* ___ ❑ former smoker *# packs?* ___ *# years?* ___
❑ cigars/pipe *how much?* ___ *# years?* ___ ❑ smokeless tobacco *how much?* ___ *# years?* ___

Alcohol use: ❑ I do not use alcohol ❑ wine- __ glasses per _____ (day, month, etc.)
❑ beer- __ cans/bottles per _____ ❑ hard liquor- __ drinks per _____

Substance abuse: ❑ I do not use recreational drugs ❑ marijuana *how much?* _____ *when?* _____
❑ LSD/hallucinogens *how much?* _____ *when?* _____ ❑ amphetamines *how much?* _____ *when?* _____
❑ heroin *how much?* _____ *when?* _____ ❑ cocaine *how much?* _____ *when?* _____ ❑ other _____

Marital status: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed
Number of children _____ Live alone? ❑ Y ❑ N Unable to drive? ❑ Y ❑ N

Sexual activity: ❑ heterosexual ❑ homosexual ❑ bisexual ❑ transgender

Family History (*Please indicate if any family members have had the following conditions)* ❑ Family history unknown

	Mother Alive? Y N	Father Alive? Y N	Sister	Brother	Son	Daughter	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Heart										
Stroke										
Cancer (type?)										
Bleeding disorder										
Other										

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Name _____
Date of Birth _____

Review of Systems

Do you have any of the following symptoms? ❑ Yes ❑ No

Systemic symptoms
- ❑ Heavy night sweats
- ❑ Involuntary weight loss
- ❑ Fatigue (tiredness)
- ❑ Fainting

Skin symptoms
- ❑ Rash
- ❑ Excessive hair

HEENT symptoms
- ❑ Hoarseness
- ❑ Vision changes
- ❑ Hearing changes
- ❑ Spinning feeling or dizziness

Pulmonary symptoms
- ❑ Frequent cough
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Difficulty breathing

Cardiovascular symptoms
- ❑ Rapid or irregular heartbeat
- ❑ Chest pain or discomfort
- ❑ Leg swelling
- ❑ Leg pain with exercise

Gastrointestinal symptoms
- ❑ Difficulty swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Decreased appetite
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black or tarry stools
- ❑ Red blood in the bowel movement
- ❑ Heartburn

Genitourinary symptoms
- ❑ Blood in the urine
- ❑ Urinary loss of control
- ❑ Delays in starting urination

Gynecologic symptoms
- ❑ Problems with menstruation
- ❑ Postmenopausal
- ❑ Irregular periods
- ❑ Inability to conceive (infertility)

Musculoskeletal symptoms
- ❑ Foot pain
- ❑ Low back pain
- ❑ Hip joint pain
- ❑ Knee joint pain

Neurologic symptoms
- ❑ Unsteady walk
- ❑ Tingling in arms or legs
- ❑ Muscle weakness
- ❑ Headaches
- ❑ Shooting pain down legs

Psychological symptoms
- ❑ Anxiety
- ❑ Depression
- ❑ Memory lapses or loss
- ❑ Insomnia
- ❑ Subject to physical abuse
- ❑ Subject to sexual abuse