



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.

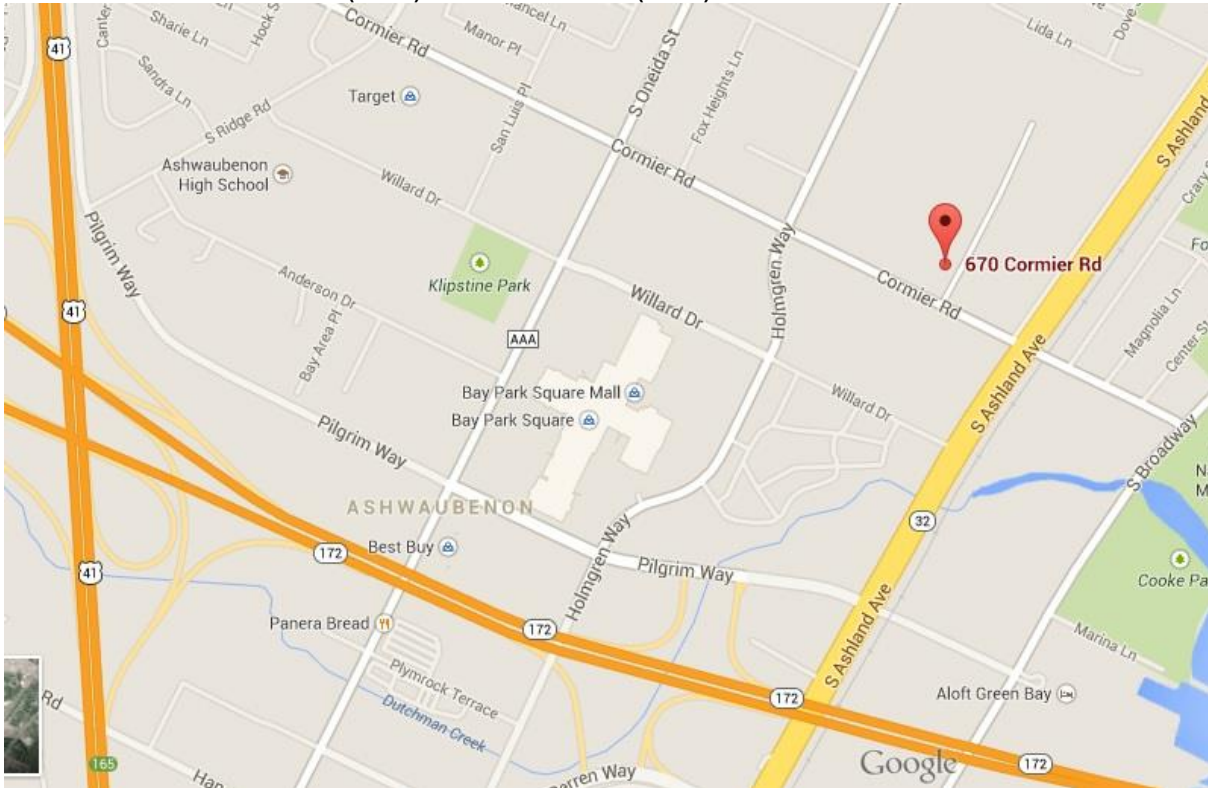
Sincerely,

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.

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 # _____

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: _____

Past Medical History

Have you ever had any medical problems? Yes No

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

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

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.)

- | | |
|---|---|
| <input type="checkbox"/> Eye operation _____ | <input type="checkbox"/> Umbilical hernia repair _____ |
| <input type="checkbox"/> Sinus operation _____ | <input type="checkbox"/> Inguinal hernia repair _____ |
| <input type="checkbox"/> Tonsillectomy _____ | <input type="checkbox"/> Incisional hernia repair _____ |
| <input type="checkbox"/> Thyroid operation _____ | <input type="checkbox"/> Dilatation and curettage _____ |
| <input type="checkbox"/> Breast biopsy _____ | <input type="checkbox"/> Tubal ligation _____ |
| <input type="checkbox"/> Mastectomy _____ | <input type="checkbox"/> Cesarean section _____ |
| <input type="checkbox"/> Coronary stent placement _____ | <input type="checkbox"/> Uterine suspension _____ |
| <input type="checkbox"/> Coronary artery bypass (CABG) _____ | <input type="checkbox"/> Hysterectomy _____ |
| <input type="checkbox"/> Heart valve repair/replacement _____ | <input type="checkbox"/> Bladder suspension _____ |
| <input type="checkbox"/> Abdominal aortic aneurysm repair _____ | <input type="checkbox"/> Prostate operation _____ |
| <input type="checkbox"/> Peripheral vascular operation (bypass of blood vessel in arm or leg) _____ | <input type="checkbox"/> Back operation _____ |
| <input type="checkbox"/> Esophagus operation _____ | <input type="checkbox"/> Other orthopedic operation (<i>e.g.</i> fracture repair, knee scope, hip replacement, etc.) _____ |
| <input type="checkbox"/> Gastrointestinal operation (<i>e.g.</i> ulcer, small intestine, etc.) _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colon operation _____ | |
| <input type="checkbox"/> Appendectomy _____ | |
| <input type="checkbox"/> Anal or rectal operation _____ | |
| <input type="checkbox"/> Gallbladder _____ | |
| <input type="checkbox"/> Pancreas operation _____ | |

Review of Systems

Name _____
Date of Birth _____

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

Colon & Rectal History

Please answer all questions to the best of your ability and ask the staff if you have any questions or concerns. Circle either *yes* or *no* or circle the word that best describes your answer.

Do you have any rectal pain? yes / no

Do you have any abdominal pain? yes / no

Do you have any rectal bleeding? yes / no

What is the color of the bleeding? (bright red / dark red / maroon / black)

How many bowel movements do you have in a day? _____

What are your bowel movements like? (loose / soft / hard)

What is the diameter of your stool? (one inch, two inches, three inches)

How long do you sit to move your bowels? (5 minutes, 10 minutes, 1/2 hour, more than 1/2 hour)

Do you have diarrhea? yes / no

Do you have constipation? yes / no

Do you have swelling around the rectum? yes / no

Have you noticed lumps or bumps coming out of your rectum? yes / no

Do you have discharge from your rectum (e.g. mucous or pus)? yes / no

Do you ever have to hurry to the bathroom to avoid an accident? yes / no

Do you have any leakage of stool? yes / no

Do you ever leak any urine? yes / no

Do you use laxatives (e.g. Miralax, Ex-lax, Milk of Magnesia, Dulcolax, enemas, suppositories) to have bowel movements? yes / no

Do you have **any** family history of colon or rectal cancer? yes / no

Have you had a colonoscopy? If so, when and where? _____

Comments: _____

Additional obstetrical questions for female patients:

of pregnancies: _____ Total # of deliveries: _____ # deliveries by Caesarean section: _____

Did you have any stitches or complications during delivery? _____