

**PATIENT INFORMATION**

First Name \_\_\_\_\_  
Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Emergency Phone # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Your Social Security # \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Family Physician \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:**

Name of Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # or SS # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Subscriber date of birth \_\_\_\_\_

**Secondary Insurance:**

Name of Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # or SS # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Relation to Patient \_\_\_\_\_  
Subscriber date of birth \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Patient's Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Name of nearest relative not living with you:  
\_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to **Dayton Colon & Rectal Center, Inc.** and to submit a claim to my insurance carrier for payment. I recognize and accept responsibility for any remaining balance after payment of benefits. I authorize exam of colon, including endoscopy and performance of minor procedures for my condition.

If service were provided at DCR Surgery Center, LLC, I request that payment of authorized benefits be made on my behalf for facility charges to DCR Surgery Center, LLC. I recognize and accept responsibility for any remaining balance after payment of benefits.

Signed \_\_\_\_\_  
Date \_\_\_\_\_



*Accredited by*

**Accreditation Association  
for Ambulatory Health Care, Inc.**

**CHIEF COMPLAINTS:**

\_\_\_\_hemorrhoids      \_\_\_\_fissure      \_\_\_\_rectal pain      \_\_\_\_rectal bleeding      \_\_\_\_constipation  
\_\_\_\_polyp      \_\_\_\_abd pain      \_\_\_\_warts      \_\_\_\_itching      \_\_\_\_diverticulitis

**HISTORY OF PRESENT ILLNESS:**

**RECTAL BLEEDING**

\_\_\_\_Bright red  
\_\_\_\_Dark red  
\_\_\_\_On the toilet paper  
\_\_\_\_On the outside of stool  
\_\_\_\_Mixed with stool  
\_\_\_\_Blood clots  
\_\_\_\_Black stools

**DURATION**

**FREQUENCY**

\_\_\_\_with each bowel movement  
\_\_\_\_once a week  
\_\_\_\_once a month  
\_\_\_\_rarely

**PAIN:**

\_\_\_\_RECTAL

\_\_\_\_severe      \_\_\_\_itching  
\_\_\_\_moderate      \_\_\_\_burning  
\_\_\_\_mild      \_\_\_\_sharp

\_\_\_\_ABDOMINAL

\_\_\_\_cramping      \_\_\_\_dull      \_\_\_\_sharp      \_\_\_\_heartburn

**DURATION**

**FREQUENCY**

\_\_\_\_with each bowel movement  
\_\_\_\_without bowel movement  
\_\_\_\_all the time  
  
\_\_\_\_with each bowel movement  
\_\_\_\_with bowel movement  
\_\_\_\_after meals

**PROTRUSTION AT RECTAL OPENING:**

\_\_\_\_reducible      \_\_\_\_non reducible

**DRAINAGE:**

\_\_\_\_bloody      \_\_\_\_pus      \_\_\_\_mucous      \_\_\_\_other

**BOWEL HABITS:**

\_\_\_\_1 to 3 times a day      \_\_\_\_hard  
\_\_\_\_more than 1-3 times a day      \_\_\_\_soft  
\_\_\_\_1 to 3 times a week      \_\_\_\_watery  
\_\_\_\_feels like stool comes down to the opening of the rectum but can't expel it out      \_\_\_\_mushy/pasty

**LIST OF LAXATIVES USED:**

**REVIEW OF SYSTEMS:**

\_\_\_\_weight gain/loss, fever      \_\_\_\_urinary difficulty  
\_\_\_\_skin diseases or rashes      \_\_\_\_anemia  
\_\_\_\_thyroid disease/diabetes      \_\_\_\_eye problems  
\_\_\_\_chest pain/heart disease      \_\_\_\_muscle/arthritis  
\_\_\_\_high blood pressure      \_\_\_\_strokes  
\_\_\_\_asthma/shortness of breath      \_\_\_\_others

**MEDICATIONS USED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST OPERATIONS:**

\_\_\_\_hemorrhoids  
\_\_\_\_colon operations  
\_\_\_\_colonoscopy  
\_\_\_\_hysterectomy  
\_\_\_\_hernia  
\_\_\_\_back surgeries  
\_\_\_\_prostate  
\_\_\_\_breast  
\_\_\_\_heart  
\_\_\_\_others

**LIST OF ALLERGIES:**

\_\_\_\_\_  
\_\_\_\_\_  
**OTHER DESCRIPTION**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL/FAMILY**

SMOKES \_\_\_\_\_PACK/DAY  
BEERS \_\_\_\_\_PER/WEEK

**FAMILY HISTORY**

\_\_\_\_CANCER\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_OTHERS\_\_\_\_\_  
\_\_\_\_\_