Colon & Rectal Associates

1811 E. BERT KOUNS, SUITE 430
SHREVEPORT, LA 71105

PHONE: (318) 424-8373
FAX: (318) 424-6477
colonandrectalassociates.com

Leaders and Innovators in
Colon and Rectal Surgery

Michael D. Stratton, MD, FACS, FASCRS
Andrew M. Werner, MD, FACS, FASCRS
Brielle R. Hebert, MD

Please find enclosed a Patient Registration that we need you to complete for your upcoming appointment. Colon & Rectal Associates has begun using an electronic health record system and this completed form is needed so that you can be entered into the new system.

Please complete this information prior to your appointment.
IF POSSIBLE, PLEASE MAIL OR FAX TO:

COLON & RECTAL ASSOCIATES
1811 E. BERT KOUNS, SUITE 430
SHREVEPORT, LA 71105
OR
FAX: (318) 424-6477

(Bring original paperwork to your appointment)

We appreciate your assistance in completing this information and returning it to us. If you are going to mail this form, please allow at least 5 days for us to receive this at our office for processing. If we do not have this at the time of your appointment, another form will need to be completed.

Thank you,

COLON & RECTAL ASSOCIATES

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Registration Form

PATIENT NAME: First _____ Middle _____ Last _____

ADDRESS: _____

CITY, STATE, ZIP: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

SEX: ☐ Female ☐ Male

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ Other: _____

UNDERSTAND ENGLISH? ☐ Yes ☐ No

ETHNICITY: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino
☐ Unknown ☐ NOT Disclosed/Declined

RACE: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American
☐ Hispanic ☐ Pacific Islander ☐ White/Caucasian
☐ Other: ☐ Unknown ☐ Not Disclosed/Declined

EMAIL: _____ (unique to patient) ☐ NONE:

TELEPHONE: Home _____ Work _____ Cell _____

EMPLOYER: _____

EMERGENCY CONTACT: _____

EMERGENCY PHONE: _____

PRIMARY INSURANCE: _____

2ND INSURANCE: _____

Please have ALL Insurance card(s) and one photo ID available when at registration for copying.

SPOUSE: Name _____ SS# _____

Employer _____ Work Phone _____

Payment for office services is due on the day of service. If you have a co-pay, this must be paid prior to seeing the doctor. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made prior to procedures/surgeries.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from my insurance plan(s) for services rendered. I understand and agree to the above.

_____ _____

Signature Date

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Patient Name: _____ Date: _____

WHAT IS THE REASON FOR TODAY'S VISIT?

_____

Our desire is to keep Primary Care Physicians and Referring Physicians informed of our findings and plans.

WHO IS YOUR PRIMARY CARE PHYSICIAN?

_____

DO YOU SEE A NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT AT THE PRIMARY PHYSICIAN'S OFFICE? WHAT IS THEIR NAME?

_____

WHICH PRIMARY CARE OR SPECIALTY PHYSICIAN (OR NP/PA) REFERRED YOU FOR TODAY'S VISIT?

_____

PREFERRED PHARMACY: _____

Address: _____

City: _____ State: _____

Phone: _____

PLEASE CHECK MAIN COMPLAINTS BELOW:

RECTAL BLEEDING:	☐ Black, tarry stool	☐ Blood mixed with stool	☐ Dark red blood	☐ Bright red blood
	☐ Bleeding with clots	☐ Into the toilet bowl	☐ On the toilet paper	
RECTAL PAIN:	☐ With bowel movement	☐ Constant	☐ Sporadic	
OTHER RECTAL SYMPTOMS:	☐ Fecal Incontinence	☐ Hemorrhoid swelling	☐ Rectal itching	
	☐ Abdominal pain	☐ Bloating	☐ Nausea	☐ Vomiting
	☐ Weight gain	☐ Weight loss	☐ Loss of appetite	☐ Fever
CHANGE IN BOWEL HABITS	☐ Diarrhea	☐ Constipation	☐ Straining	
	☐ Stools per day 1 2 3 4 5 6 or more		☐ Stools per week 6 5 4 3 2 1 less than one	
	☐ Stool softener	☐ "Natural" laxative	☐ Fiber supplement	
	☐ FiberCon	☐ MiraLAX	☐ Other laxatives _____	
DIET:	☐ High fiber	☐ High fiber cereal	☐ Lactose free	
BEVERAGES:	☐ Coffee	☐ Tea	☐ Cokes/carbonated drinks	
WATER:	☐ Less than 4 glasses/day	☐ 4-8 glasses/day	☐ More than 8 glasses/day	

HISTORY OF FOOD INTOLERANCE?

_____

_____

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Patient Name: _____ Date: _____

Review of Symptoms

OTHER SYMPTOMS: *Check ONLY those that are CURRENTLY a problem.*

- ☐ Fatigue
- ☐ Blurred vision
- ☐ Bleeding gums
- ☐ Hearing loss
- ☐ Rapid or Irregular heart beat
- ☐ Ankle/feet swelling
- ☐ Shortness of breath
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Delay starting urinary stream
- ☐ Impotence
- ☐ Bleeding complication after pulled tooth or surgery
- ☐ Easy bruising
- ☐ Excessive thirst
- ☐ Hot flashes
- ☐ Memory loss
- ☐ Nose bleeds
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Pain when urinating
- ☐ Possibly pregnant
- ☐ Joint pain
- ☐ Back pain
- ☐ Rash
- ☐ Itching

FAMILY HISTORY: *Check each that applies to family members.*

FAMILY HISTORY OF COLON CANCER:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Son/Daughter
- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ First cousin

FAMILY HISTORY OF COLON POLYPS:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Son/Daughter
- ☐ Grandparent
- ☐ Aunt/Uncle
- ☐ First cousin

OTHER FAMILY HISTORY. CONCERNS INVOLVING CLOSE RELATIVES:

- ☐ Breast cancer
- ☐ Crohn's disease
- ☐ Hemophilia
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Ulcerative colitis
- ☐ Uterine cancer

Social History

TOBACCO:
- ☐ Never smoked
- ☐ Quit smoking, Year _____
- ☐ Currently Smoke – ☐ Cigarettes ☐ Cigars ☐ Dip/chew tobacco

ALCOHOL: ☐ None ☐ Social ☐ Daily ☐ Alcohol abuse ☐ Drug abuse

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYMENT: ☐ Employed ☐ Retired ☐ Unemployed ☐ Homemaker

Occupation _____

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Patient Name: _____ Date: _____

Past Medical History

Check Medical Problems that apply to you.

☐ Colon cancer ☐ Colon polyps ☐ Crohn's disease ☐ Ulcerative colitis☐ Diverticulitis ☐ Hemorrhoids ☐ Anal fissure ☐ Anorectal fistula

☐ Ovarian cancer ☐ Breast cancer ☐ Other cancer: _____

☐ GERD ☐ Stomach ulcer ☐ Irritable Bowel Syndrome ☐ Duodenal ulcer

☐ Cirrhosis ☐ Hepatitis

☐ Sleep apnea ☐ COPD ☐ Asthma ☐ Pulmonary Embolus

☐ Heart attack ☐ High blood pressure ☐ Deep vein thrombosis ☐ Atrial fibrillation
☐ Stroke ☐ Congestive heart failure ☐ Valvular heart disease

☐ Thyroid disease ☐ Diabetes/ insulin ☐ Diabetes/ no insulin

☐ Number of vaginal deliveries: _____ ☐ Number of C-sections: _____

☐ Kidney stones ☐ BPH (enlarged prostate) ☐ Renal failure (dialysis)

☐ Arthritis ☐ Osteoporosis ☐ Psoriasis ☐ Melanoma

☐ Anxiety ☐ Seizures ☐ Depression ☐ Alzheimer's ☐ Parkinson's

☐ TB ☐ HIV ☐ Sexually transmitted diseases

☐ Glaucoma ☐ Macular degeneration ☐ Cataracts

☐ Other Medical Problems: _____

_____

_____

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Past Surgical History

Check your previous surgeries.

☐ Last colonoscopy Year _____ Doctor or Hospital _____

☐ Colon resection for cancer Year _____ Doctor or Hospital _____

☐ Colon resection NOT for cancer Year _____ Doctor or Hospital _____

☐ Hemorrhoidectomy Year _____ Doctor or Hospital _____

☐ Anal fissure Year _____ Doctor or Hospital _____

☐ Anorectal abscess drained Year _____ Doctor or Hospital _____

☐ Appendectomy ☐ Gallbladder ☐ Hernia repair ☐ Gastric bypass ☐ Gastric band

☐ Thyroid ☐ Tonsillectomy ☐ Lung surgery

☐ Vascular bypass ☐ Carotid surgery ☐ Open heart surgery ☐ Heart valve replacement

☐ Benign breast biopsy ☐ Breast cancer ☐ Breast Implants ☐ Breast reduction

☐ Nephrectomy ☐ Prostatectomy ☐ Prostate radiation

☐ Tubal Ligation ☐ Ovary removed - one ☐ Ovaries removed - both

☐ Bladder suspension ☐ Vaginal hysterectomy ☐ Hysterectomy- abdominal

☐ Joint replacement ☐ Cervical disk ☐ Lumbar disk ☐ Cataract

☐ Other Surgeries: _____

Allergies

DRUG ALLERGIES: ☐ Penicillin ☐ Sulfa ☐ Cipro ☐ Other _____

OTHER MAJOR ALLERGIES: ☐ Shell fish ☐ Peanuts ☐ Latex ☐ Other _____

HISTORY OF MAJOR ALLERGIC REACTION?

☐ Shock ☐ Difficulty Breathing ☐ Lips/tongue swelling ☐ Extensive rash

What caused the MAJOR allergic reaction? _____

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Patient Name: ______________________________ Date: ____________________

Medications

Include Dosage (50 Mg, 100 Grams, Etc); How Taken (Once Daily, Twice A Day, Etc.)

MEDICATION:	PRESCRIBING DOCTOR: