

CLINIC FOR COLON & RECTAL SURGERY, P.A.

Robert L. Baird, M.D.
William R. Nuessle, M.D.
Robert H. Campbell, Jr., M.D.

115 MANNING DRIVE, SUITE D101
HUNTSVILLE, ALABAMA 35801
(256) 533-6070

Javad Golzarian, M.D.
Stephen F. Clark, M.D.

PLEASE PRINT

Name: _____ Date of Birth: _____ Sex: M or F

Social Security Numer: _____ Marital Status: _____ Religion: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Place of Employment: _____

Spouse / Parent Name: _____ Spouse / Parent Date of Birth: _____

Spouse / Parent Employer: _____ Business Phone: (_____) _____

Social Security Number: _____ Cell Phone: (_____) _____

Emergency Contact (Outside of the Home): _____ Phone: (_____) _____

What physician referred you to us? Dr. _____

Have you seen any of our doctors before? _____ If so, who _____

Primary Insurance Company: _____ Contract #: _____ Group #: _____

Subscriber Name: _____ Relation: _____

Secondary Insurance Company: _____ Contract #: _____ Group #: _____

Subscriber Name: _____ Relation: _____

PATIENT'S OR AUTHORIZED SIGNATURES

I authorize the release of medical information necessary to process any insurance claim on my behalf. A copy of this authorization shall be considered as valid as the original.

SIGN: _____ **Date:** _____

I authorize payment to the Clinic for Colon & Rectal Surgery of benefits otherwise payable to me. I understand that I am financially responsible to those indicated above for charges not covered by this authorization. I also agree that, should I not assume this financial responsibility any credit action is necessary, I will pay for those costs in addition to the amount of the doctor's charge.

SIGN: _____ **Date:** _____

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TELEPHONE CONSENT

I/we the undersigned, give prior express consent to Clinic for Colon & Rectal Surgery, P.A., its employees, and/or agents, to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance and/or payment.

Signature

Date

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____ have available to me a copy of Clinic for Colon & Rectal Surgery, P.A.'s Notice of Privacy Practices.

Signature of Patient

Date

Who may we release your information to? Please mark appropriately.

_____ Relation _____

_____ Relation _____

_____ Relation _____

_____ Relation _____

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MEDICAL INFORMATION

Patient's Name: _____ Date: _____

Pharmacy Name / Location: _____

Please List Any Allergies You Have to Medication: _____

Are You Allergic to Latex? Yes No

Medication Name	Strength	Dosage	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you Taking Anticoagulants (blood thinners) Coumadin Plavix Aspirin Aggrenox
 Other _____

Please List any Surgical Procedure you have Undergone: Hysterectomy Colon Gall Bladder Heart
 Other: _____

Have you had Significant Medical Problems?

- Heart Disease: _____ Lung Disease: _____
- Blood Pressure: High _____ Low _____ Diabetes: Type I _____ Type II _____
- Kidney: _____ Liver Disease: _____
- Blood Clots Leg _____ Arm _____ Other _____
- Other: _____

Do you have a Family History of Colon Cancer? If yes, please indicate family member(s):

Do you have a Family History of Diabetes? If yes, please indicate family member(s):

Do you have a Family History of Heart Disease? If yes, please indicate family member(s):

Do you Smoke? Yes No If yes, how much? _____

Do you Drink Alcohol? Yes No If yes, how much? _____

Are you HIV Positive? Yes No

OVER

CLINIC FOR COLON & RECTAL SURGERY, P.A.

Have You Recently Experienced The Following:

GENERAL:

- Chills
- Fatigue
- Fever
- Loss of Appetite
- Sweats
- Weight Loss If yes, how much _____

HEAD, EARS, EYES, NOSE and THROAT:

- Blurred Vision
- Deafness
- Other Vision Change
- Nose Bleeds
- Headaches
- Mouth Sores
- Sore Throat
- Dizziness
- Voice Change
- Swallowing Difficulties

RESPIRATORY:

- Asthma
- Cough
- Shortness of Breath
 - At Rest
 - On Exertion
- Coughing Blood or Pus

CARDIAC:

- Chest Pain
- Extremity Pain on Walking
- Smothering while Lying Down
- Palpitations

SKIN:

- Easy Bruising
- Change in Skin Color
- Skin Itching
- Rashes
- Skin Swelling

OTHER:

- Abnormal Bleeding
- Intolerance to Heat or Cold

GASTROINTESTINAL:

- Abdominal Pain
- Change in Bowel Habit
- Constipation
- Diarrhea
- Change in Stool Caliber
- Change in Stool Color
- Incontinence to:
 - Gas
 - Liquid Stool
 - Solid StoolHow often? _____
- Heartburn
- Blood in Stool
- Rectal Bleeding
- Hemorrhoids
- Anal or Rectal Pain
- Nausea
- Vomiting
- Anal or Rectal Drainage

GENITOURINARY:

- Pain with Urination
- Blood in the Urine
- Foul-Smelling Urine
- Difficulty Urinating
- Genital Sores
- Sexual Dysfunction

MUSCULAR:

- Joint Pain
- Joint Swelling
- Muscle Pain
- Muscle Weakness

NEUROLOGICAL:

- Tremors
- Loss of Sensation of Taste
- Loss of Memory
- Hallucinations
- Depression
- Anxiety

NONE OF THE ABOVE