

THE OREGON HEMORRHOID CLINIC
NEW PATIENT PROCTOLOGY INFORMATION

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Please present your photo ID & insurance card to front desk.

Full Name: _____ **Birth date:** _____

Height: _____ **Weight:** _____ **Sex:** M F or _____

Address: _____

City, State, Zip: _____

Phone: _____ **Cell:** _____ **Work:** _____

Preferred Method of Contact: __ Home __ Cell __ Work **OK to leave message?** Yes No

Marital Status: Single ___ Married ___ Divorced ___ Widow ___ Other ___

Email: _____

Employer Name: _____ **Occupation:** _____

How did you hear about our clinic? _____

Emergency Contact: _____ **Phone:** _____

Relationship to emergency contact: _____

By way of signature, I am authorizing treatment and accept full financial responsibility.

Patient signature: _____ **Date:** _____

Parent/Guardian signature: _____

INSURANCE INFORMATION: Please list your relationship to the insured below:

Self ___ Spouse ___ Child ___ Other ___

Name of Primary Insured (if not self): _____ **DOB:** _____

Insured Employer: _____

Reason for initial visit: _____

Have you or any family member been diagnosed with colon or rectal cancer?

No ___ Yes ___ Explain: _____

Have you had a colonoscopy? No ___ Yes ___ When ___ Date your symptoms began _____

Have you had prior hemorrhoid problems? No ___ Yes ___ Surgery? No ___ Yes ___

Problems with: Constipation ___ Rectal Pain ___ Rectal Bleeding ___ Itching ___

Bleeding while passing stool ___ Anal discharge ___ Diarrhea ___

On a scale from 1 to 10, what is your pain level today? ___ # of BMs per day _____

Review of symptoms:

please circle symptoms which you are **currently** experiencing:

Systemic: fever fatigue weight loss night sweats

Cardiac: chest pain shortness of breath with activity irregular heart beat

Pulmonary: shortness of breath cough

GI: abdominal pain nausea/vomiting heartburn diarrhea constipation rectal bleeding

Endocrine: weight gain increased thirst intolerance of heat intolerance of cold

Hematology: anemia bleeding swollen glands

Rheumatology: joint pain joint swelling

GU: painful urination blood in urine urine slow to start increased urination

GYN: unusual vaginal bleeding unusual vaginal discharge

Neurology: seizures dizziness severe headaches unusual numbness/tingling

Dermatology: rash changes in moles unusual skin lesions

Psych: depression anxiety chronic insomnia

Musculoskeletal: Please check if you have problems with:

Neck ___ Mid-back ___ Low back ___ Shoulder ___ Arm ___ Leg ___ Joints ___ Walking ___

Pain today from 1 to 10: ___ Pain increased by: _____ Decreased by: _____

Please list other symptoms you are concerned about:

For women: Name of your OBGYN: _____

When was your last mammogram? _____

When was your last PAP smear? _____

Have you ever had a bone density test? When? _____

Have any of the above been abnormal? _____

Last Menstrual Period: _____ Are you pregnant? _____

Number of children: _____

Please list method of birth control: _____
Have you gone through menopause? When? _____
Have you ever been on hormone therapy? When? _____

For Men: Name of your urologist: _____
When was your last prostate blood test? _____
When were your last prostate and testicular exams? _____
Have any of the above been abnormal? _____

Personal Information: please list any of the following that apply

Major Illnesses/Accidents: _____

Surgeries: _____

Medications: _____

Please **circle** any of the following blood thinning medications you are currently taking:

Advil Aspergum Midol Sinutab
Alka Seltzer Aspirin Motrin Vitamin E
Aleve Excedrin Pepto Bismol Fish oil
Coumadin Ibuprofen Plavix Other: _____

List allergies to medications or others (i.e., latex) _____

Family history of disease? Please indicate which conditions are present in your family:

Heart Attacks Diabetes Bleeding Disorders
 High Blood Pressure High Cholesterol Thyroid Problems
 Kidney Disease Seizures Depression
 Liver Disease Strokes Osteoporosis
 Cancer(indicate type and family member) _____

Social History

Do you smoke currently? _____ If no, have you ever smoked? _____
From what ages? _____ On average, how many packs a day? _____
Do you drink alcohol currently? _____ If yes, how much? _____
If no, did you ever drink significant amounts of alcohol in the past? _____

OFFICE POLICY AND PRIVACY POLICY

OFFICE HOURS

Our office is open Monday thru Friday from 8:00AM to 4:00PM

If an appointment cancellation is necessary, please notify our office at least 24 hours before the scheduled

FEES AND FINANCAIL POLICY

Payment of fees is the direct responsibility of the patient. We collect payment at the time of service. You may pay by cash, check, Visa, or MasterCard, or Discover. If the patient misses more than one appointment without notice of cancellation, the patient will be assessed a Missed Appointment Fee.

INSURANCE BILLING

As a courtesy to you, we will bill your insurance company. When time allows, we will call and check your insurance benefits. **This is not a guarantee that you will be covered**, as benefits are determined when your insurance processes your claim. Should the insurance deny your claim, we ask that you pay our office directly and contact your insurance company.

SUMMARY OF OUR PRIVACY POLICY

We strongly believe in maintaining your private healthcare information. We do not disclose any non-public information about you to anyone, except as permitted by law, or to process an insurance claim. We maintain physical and procedural safeguards that comply with Federal and State regulations to protect information about you. A complete copy of our privacy policy (4pgs) is available upon request.

I have read and understand the above policies of this office, and I agree with them. I consent to treatment with Dr. Brett J. Hubbard., and/or Dr. Steven L. Gardner., and/or Dr. Maria F. Siri., and/or Dr. Lauren Herschorn. I accept full responsibility for all expenses incurred by, or on the account of the patient. In the event of non-payment, I understand my account will be turned over to a collection company to pursue my balance, and I will pay the cost of collection and legal fees should that be required.

LEGIBLE SIGNATURE REQUIRED

Signature of Patient/Guardian _____

Date Today: _____