# THE OREGON HEMORRHOID CLINIC

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***Please present your photo ID and insurance card to the front desk.***

## NEW PATIENT PROCTOLOGY INFORMATION

### SECTION 1 — PATIENT INFORMATION

Full Name:

Date of Birth: Height: Weight: Sex: M F Other

Street Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work:

Preferred Contact: Home Cell Work OK to leave a message? Yes No

Marital Status: Single Married Divorced Widowed Other

Email Address:

Employer Name: Occupation:

How did you hear about our clinic?

Emergency Contact Name: Phone:

Relationship:

**Patient Signature:** **Date:**

**Parent / Guardian Signature:** **Date:**

### SECTION 2 — INSURANCE INFORMATION

Relationship to Insured: Self Spouse Child Other

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

Insured's Employer:

## SECTION 3 — VISIT DETAILS & GI HISTORY

Reason for initial visit:

Have you or any family member been diagnosed with colon or rectal cancer? No Yes

If yes, explain:

Have you had a colonoscopy? No Yes If yes, when:

Date your symptoms began:

Prior hemorrhoid problems? No Yes Prior surgery? No Yes

**Problems with (check all that apply):**

- Constipation
- Rectal Bleeding
- Bleeding while passing stool
- Diarrhea
- Rectal Pain
- Itching
- Anal discharge

Pain level today (1–10): Bowel movements per day:

## SECTION 4 — REVIEW OF SYMPTOMS (check all that apply)

| | |
|---|---|
| **Systemic:** | Fever Fatigue Weight loss Night sweats |
| **Cardiac:** | Chest pain SOB with activity Irregular heartbeat |
| **Pulmonary:** | Shortness of breath Cough |
| **GI:** | Abdominal pain Nausea/vomiting Heartburn Diarrhea Constipation Rectal bleeding |
| **Endocrine:** | Weight gain Increased thirst Heat intolerance Cold intolerance |
| **Hematology:** | Anemia Bleeding Swollen glands |

*SECTION 4 — REVIEW OF SYMPTOMS (continued)*

**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 Numbness/tingling

**Dermatology:** Rash Changes in moles Unusual skin lesions

**Psych:** Depression Anxiety Chronic insomnia

**Musculoskeletal:** Neck Mid-back Low back Shoulder Arm Leg Joints Walking difficulty

Pain level today (1–10):

Pain increased by:

Pain decreased by:

Other symptoms of concern:

## SECTION 5 — WOMEN'S HEALTH

Name of OB/GYN:

Last mammogram: Last PAP smear:

Bone density test? No Yes If yes, when:

Have any of the above been abnormal? No Yes

Last menstrual period: Currently pregnant? No Yes

Number of children: Method of birth control:

Menopause? No Yes If yes, when: Hormone therapy? No Yes

If hormone therapy, when:

## SECTION 6 — MEN'S HEALTH

Name of urologist:

Last prostate blood test:

Last prostate and testicular exams:

Have any of the above been abnormal? No Yes

## SECTION 7 — PERSONAL / MEDICAL HISTORY

Major Illnesses / Accidents:

Surgeries:

Current Medications:

**Blood-thinning medications currently taking (check all that apply):**

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

Allergies (medications, latex, other):

## SECTION 8 — FAMILY HISTORY (check all that apply)

| | | |
|---|---|---|
| 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:

## SECTION 9 — SOCIAL HISTORY

Do you currently smoke? No Yes

If no, have you ever smoked? No Yes Ages smoked: Packs/day:

Do you currently drink alcohol? No Yes

If yes, how much per week?

Have you ever drunk significant amounts of alcohol in the past? No Yes

## SECTION 10 — OFFICE POLICY & PRIVACY NOTICE

**Office Hours:**

Monday through Friday, 8:00 AM – 4:00 PM.

**Appointment Cancellations:**

We require at least 24 hours' advance notice for cancellations or rescheduling. A fee may be charged for missed or late-cancelled appointments.

**Payment Policy:**

Payment is due at the time of service. We accept cash, personal check, Visa, MasterCard, and Discover. Financing options may be available upon request.

**Insurance Billing:**

As a courtesy, we will submit claims to your insurance carrier on your behalf. However, your insurance coverage is not guaranteed until your claim has been processed and approved. You are responsible for any co-pays, deductibles, or balances not covered by your plan.

**Insurance Denials:**

If your insurance carrier denies a claim for any reason, you remain responsible for the full balance owed for services rendered.

**Privacy & HIPAA:**

Your personal health information is collected and maintained in strict confidence in accordance with the Health Insurance Portability and Accountability Act (HIPAA). A complete copy of our Notice of Privacy Practices is available upon request at the front desk or will be provided to you electronically.

## ACKNOWLEDGMENT, CONSENT & AUTHORIZATION

I certify that the information I have provided on this form is true, accurate, and complete to the best of my knowledge. I understand that withholding or misrepresenting information may affect my care. I have read and understand the office policies and privacy notice summarized above, and I consent to examination, treatment, and financial responsibility as outlined. I authorize The Oregon Hemorrhoid Clinic to release health information as necessary for billing and insurance purposes.

**Patient Signature:** _____ **Date:** _____

**Parent / Guardian Signature:** _____ **Date:** _____

*Thank you for choosing The Oregon Hemorrhoid Clinic. We look forward to serving you.*