



Valerie R. Dyke, MD, FACS, FASCRS
 Janette U. Gaw, MD, FACS, FASCRS
 Nagesh B. Ravipati, MD, MS, FRCSEd
 Jeffrey A. Neale, MD
 Colorectal Surgery



The Colorectal Institute

Telephone: 239.275.0728 · Fax: 239.275.6947

PLEASE PRINT CLEARLY:

Date: _____

NAME: _____ SSN: _____

SEX: MALE FEMALE AGE: _____ BIRTHDATE: _____

MARITAL STATUS: S M W D SPOUSE/PARTNER'S NAME: _____

HOME PHONE: _____ CELL PHONE _____

ALTERNATE NUMBER(S) TO CONTACT YOU: _____

LOCAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OUT OF STATE ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S EMPLOYER: _____

WORK PHONE: _____ YEARS EMPLOYED: _____

POSITION: _____

INSURANCE INFORMATION

PLEASE PRESENT ALL INSURANCE CARD(S) FOR OUR RECORDS

PRIMARY INSURANCE _____

ID# _____ GROUP/EMPLOYER _____

SECONDARY INSURANCE: _____

ID# _____ GROUP/EMPLOYER _____

REFERRING DOCTOR: _____ PHONE NUMBER: _____

IF INSURED IS OTHER THAN THE PATIENT

INSURED'S NAME: _____ BIRTHDATE: _____

SSN: _____ RELATIONSHIP TO PATIENT: _____

Welcome to The Colorectal Institute

Valerie R. Dyke, MD Janette U. Gaw, MD Nagesh B. Ravipati, MD Jeffrey A. Neale, MD

Date: _____

Patient Name: _____ Male Female Age: _____

Referring Physician: _____ Primary Care Physician: _____

If not referred, how did you hear about us? _____

Reason for Visit: _____

ALLERGIES: _____

HPI: Check if you **currently have or recently** have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bowel obstruction | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ascites (abdominal fluid) | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Changes in Bowel Habits |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Abnormal liver tests | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Jaundice (yellow eyes or skin) | <input type="checkbox"/> Other _____ |

Previous Tests

Doctor/Location

Date

Results

Upper Endoscopy (EGD) _____

Colonoscopy _____

Sigmoidoscopy _____

Recent tests: x-rays, CT scans, MRI _____

PMH: Check if you have been diagnosed with:

- | | |
|---|--|
| <input type="checkbox"/> Anemia/low blood counts | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Blood clots lungs or legs | <input type="checkbox"/> HIV |
| <input type="checkbox"/> _____ Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ |

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Patient Name: _____

Date: _____

List previous surgeries or hospitalizations:

<u>Year</u>	<u>Procedure/Reason</u>	<u>Facility</u>

Circle if you take:

Advil Aspirin Excedrin Aggrenox BC powder Ticlid Ibuprofen Aleve Motrin
Coumadin Plavix

List all medications you are taking. (Include dosage and how you take them)

Include over-the-counter medications and health food store products.

Social History:

- Married Single Divorced Widowed Separated Life partner
- I never smoked I quit smoking _____ (months/years) ago I usually smoke cigarettes/cigars.
- I smoke _____ (cigarettes/packs) per (day/week/month) for _____ (months/years).
- I never drink alcohol I quit drinking alcohol _____ (months/years) ago.
- I have _____ drinks per (day/week/month/year) for the past _____ (months/years).
- I usually drink / used to drink (liquor/wine/beer).

Recreational drug use: (Present/Past) Yes No Name/Last used: _____

Family History: Please list if any **blood relatives have had:**

Diabetes Colon Cancer Crohn's Disease
Heart Disease Colon Polyps Ulcerative colitis
High Blood Pressure Celiac disease Stroke
Any other significant disease/illness

Relative **Disease** **Relative** **Disease**

Mother		Aunts	
Father		Uncles	
Brothers		Grandparents	
Sisters		Other	

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Patient Name: _____

Date: _____

If part-time resident: name, address and phone number of your out-of-state physician:

Physician: _____ Phone #: _____

Address: _____

In case of an emergency, whom should we contact: _____

Emergency Contact Phone Number(s): _____

(AN EMERGENCY CONTACT IS REQUIRED FOR ALL PATIENTS)

POWER OF ATTORNEY (POA): IF THE PATIENT HAS A COURT DESIGNATED POA REPRESENTATIVE, PLEASE ATTACH A COPY OF THE LEGAL DOCUMENTATION.

GUARDIAN/PARENT INFORMATION FOR TREATMENT OF A MINOR

If patient is a minor, please complete the following section

Mother's Name _____ Employer _____

Address _____

Contact Number(s) _____ SS# _____

Father's Name _____ Employer _____

Address _____

Contact Number(s) _____ SS# _____

If you do not have your insurance cards, payment is expected in full at the time services are rendered, unless other arrangements are made in advance. We WILL NOT attempt to locate insurance information for you. ***ALL co-payments and deductibles are collected at the time services are rendered.***

Read carefully the following information and understand that this is a lifetime authorization: I understand that I am responsible for all services rendered by The Colorectal Institute. In the event my insurance carrier does not pay the claim(s), I understand that it is my responsibility to seek resolution of the claim(s). I hereby assign benefits to The Colorectal Institute and allow the release of my medical information to my insurance carrier(s), Medicare, and any physician's referral.

I understand the above and certify that all the information is accurate to the best of my knowledge.

SIGNATURE _____ DATE _____

Patient, POA, Guardian (if patient is a minor)



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**PATIENT CONSENT FOR USE AND DISCLOSURE OF
 PROTECTED HEALTH INFORMATION**

Patient Name: _____ **Date:** _____

With my consent, The Colorectal Institute may use and disclose Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to The Colorectal Institute Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

The Colorectal Institute reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

The Colorectal Institute
 13770 Plantation Rd., Suite 2
 Fort Myers, Florida 33912

With my consent, The Colorectal Institute may disclose PHI to others who may assist in my medical care, such as a spouse. The Practice may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assists the Practice in carrying out TPO. This would include appointment reminders, insurance items and any calls pertaining to my medical care.

I have the right to request that The Colorectal Institute restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to The Colorectal Institute's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Colorectal Institute may decline to provide treatment to me/my child.

I, give permission to the employees of the Colorectal Institute to release my medical information to the following family member, friend or designated patient representative.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I may revoke the above permission at any time in writing.

 Patient or Authorized Representative Signature

 Date

OR

I, _____ **REQUEST THAT ALL MEDICAL INFORMATION BE
 DISCUSSED WITH ONLY ME, AND NO OTHER FAMILY MEMBER.**

 Patient or Authorized Representative Signature

 Date

Ft. Myers Office - 13770 Plantation Rd., Suite 2 · Ft. Myers, FL 33912 (mailing address)
Cape Coral Office - 2721 Del Prado Blvd., Suite 210 · Cape Coral, FL 33904
Bonita Springs Office - 3501 Health Center Blvd., Suite 2145 · Bonita Springs, FL 34135
Lehigh Acres Office - 1530 Lee Blvd., Suite 2100 · Lehigh Acres, FL 33936



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LIFETIME AUTHORIZATION
MEDICARE CERTIFICATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable to the physicians or organizations furnishing the services or authorize such physicians or organizations to submit claims to Medicare for payment.

Signed: _____ Date: _____

PRINTED NAME: _____

Medicare Policy Number: _____

03/2011