



Valerie R. Dyke, M.D., FACS, FASCRS  
 Janette U. Gaw, M.D., FACS, FASCRS  
 Cesar A. Santiago, M.D.  
 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: \_\_\_\_\_

**INSURANCE INFORMATION**

**\*PLEASE PRESENT ALL INSURANCE CARD(S) FOR OUR RECORDS\***

PRIMARY INSURANCE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

ID# \_\_\_\_\_ GROUP \_\_\_\_\_

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, M.D.    Janette U. Gaw, M.D.    Cesar A. Santiago, M.D.

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: _____            |

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.**

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**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

<u>Relative</u>	<u>Disease</u>	<u>Relative</u>	<u>Disease</u>
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Mother	Aunts
Father	Uncles
Brothers	Grandparents
Sisters	Other

Patient Name: \_\_\_\_\_

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):** \_\_\_\_\_

**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**

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  
 2675 Winkler Avenue, Suite 130  
 Fort Myers, Florida 33901

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: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\_\_\_\_\_  
 Patient or Authorized Representative Signature \_\_\_\_\_  
 Date

**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** - 2675 Winkler Ave., Suite 130 · Ft. Myers, FL 33901 (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: \_\_\_\_\_