Please Print

Central Jersey Colon and Rectal Surgeons, P.A.

Today's date:____________________

Last Name:__________________ First Name:__________________ Middle Initial:__________ Sex: M / F
Birthdate:________________ Age:____________
Social Security #:__________________________ Marital Status: S M W D Number of Children:________
E-mail Address: ________________________________
Home Phone:__________________________ Alternate Phone: __________________
Weight:__________ Height: __________ Occupation: __________________
Home Address:________________________________
Street Town State and Zip

* Referring Physician or Primary Physician name:____________________ Phone # ____________
Do you require antibiotics before dental appointments? ____________________
Are you allergic to any medications?______________ If yes, please specify: ______________

Previous surgeries: type, dates, hospitals: ____________________

Do you have any history of disease of the heart, lungs, kidney, blood pressure? ______________ If yes, please explain:____________________

Is there any history of cancer or diabetes in your family? ____________________
If you are on any medications now, please list:____________________

Name of your insurance company: ____________________
If someone other than yourself is the policyholder, please complete the following:
Name:__________________ SS#:______________ Birthdate: __________
Relationship to you: ____________________

(Please present insurance cards to be copied.)

FORM 152862 R:06/13 ITEM 8:01

Central Jersey Colon & Rectal Surgeons
HEALTH HISTORY

Patient Name ______________________ Age ________ Birth Date ______________ Today's Date______________

Chief Complaint____

Do you have a Personal History of Colon Cancer? Yes No
Do you have a Family History of Colon Cancer? Yes No Relationship: ________________
Do you have a Personal History of Colon Polyps? Yes No
Do you have a Family History of Colon Polyps? Yes No Relationship: ________________

Past Medical History
Have you ever had the following?

Whooping Cough............yes no
Scarlet Fever..................yes no
Hemorrhoids..................yes no
Mitral Valve Prolapse.......yes no

Rheumatic Fever...........yes no
Cancer........................yes no
Date of last chest x-ray__________
Bleeding Tendency..........yes no

Venereal Disease...........yes no
Polio...........................yes no
Aids or HIV+.................yes no
Heart Disease.................yes no

Diabetes............yes no
Hernia...............yes no
Hepatitis............yes no
Any other?_____________

Previous Hospitalizations/Surgeries/Serious Illnesses
(Please list when and where)

Medications (include nonprescription)

Patient Social History
Marital Status: S M D W Use of Alcohol: Never_______ Rarely_______ Moderate_______ Daily_______
Use Of Drugs: Never_______ Type/Frequency_______________________________
Use Of Tobacco: Never_______ Current packs per day_________ Previously, but quit_______________

Family Medical History	Diseases	If Deceased, Cause Of Death
Father		
Mother		
Siblings		

Review Of Systems:
Constitutional Symptoms:
General good health lately ....Yes No
Recent weight change..........Yes No
Fever..............................Yes No
Fatigue............................Yes No
Headaches........................Yes No

Gastrointestinal:
Loss of appetite.................Yes No
Change in bowel movements. Yes No
Nausea or vomiting............ Yes No
Frequent diarrhea...............Yes No
Painful bowel movements or constipation?
.... Yes No
Rectal bleeding or blood in stool
.... Yes No
Abdominal Pain................ Yes No

Genitourinary:
Frequent urination...............Yes No
Burning or painful urination.. Yes No
Blood in the urine............ Yes No
Change in force of strain when urinating
.... Yes No
Incontinence or dribbling.... Yes No
Kidney stones.................. Yes No
Sexual difficulty................ Yes No
Male-testicle pain.............. Yes No

Female- pain with periods.... Yes No
Female- irregular periods..... Yes No
Female- vaginal discharge.... Yes No
Female- # of pregnancies___________
Female- # of miscarriages___________
Female- Date of last pap___________

Hematologic/Lymphatic:
Slow to heal after cuts....... Yes No
Bleeding or bruising tendency Yes No
Anemia...........................Yes No
Phlebitis......................... Yes No
Past transfusion................ Yes No
Enlarged glands................ Yes No
Allergic/Immunologic:
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics Yes No
Morphine, Demerol, or other narcotics
.... Yes No
Novocain or other anesthetics Yes No
Aspirin or other pain remedies Yes No
Tetanus antitoxin or other serums
.... Yes No
Iodine, Methiolate or other antiseptic..
.... Yes No
Other drugs/medications

____

Known Food allergies:

Environmental Allergies:

Integumentary (skin, breast)
Rash or itching................. Yes No
Change in skin color........... Yes No
Change in hair or nails...... Yes No
Varicose veins................. Yes No
Breast pain..................... Yes No
Breast lump...................... Yes No
Breast discharge................ Yes No

Your Pharmacy:
Name:____________________
Address:
____
____

Phone #: ________________

Please sign back of this page

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

I authorize the release of any information requested by my insurance carriers, my attorney, or my employer. I also hereby authorize payment of medical benefits from my insurance company directly to Central Jersey Colon and Rectal Surgeons, PA for all services rendered.

____ __________________________
Signature of Patient or Parent/Guardian of minor patient Date

I hereby acknowledge that I have freely chosen to obtain treatment by Central Jersey Colon and Rectal Surgeons, PA with the knowledge and understanding that I bear full and sole responsibility for any and all charges incurred during my course of care. I also bear full responsibility for pursuing any appeal of a decision by my health insurance carrier to deny or limit coverage for any reason. Any denial or limitation of coverage by my health insurance carrier shall not diminish or otherwise affect my obligation of full payment to the practice for all services rendered.

I have carefully read this acknowledgement and fully understand its content. I understand that this acknowledgement is a binding contract between me and the practice, and I sign it of my own free will.

____ __________________________
Signature of Patient Date

Thank you

Central Jersey Colon and Rectal Surgeons, PA
704 Route 202 South
Bridgewater, NJ 08807

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that the practice is required to notify affected individuals of a breach of their unsecured PHI.

I understand that I have the right to enter into an advance directive. An advance directive means a written statement of your instructions and directions for health care in the event of my future decision making incapacity. An advance directive may include a proxy directive or an instruction directive, or both. (N.J.A.C. 8:43A-1.3)

I understand that I have the right to make informed decisions regarding my care including the right to make decisions concerning the right to accept, refuse, or choose from alternatives of medical and/or surgical treatment.

By signing this disclosure you or your legal representative acknowledge that: (1) you are receiving this notice prior to the date of the procedure; (2) you have been informed of the financial interests of the practitioners in this office; (3) you have the right to enter into an advance directive; (4) you have received the "Notice of Privacy Practices."

I hereby request the following individuals to have access to my Personal Health Information:

1.____

2.____

3.____

Patient Name:

____

Signature:

____

Date:

____

Central Jersey Colon and Rectal Surgeons, PA

704 Route 202 South, Bridgewater NJ 08807

PATIENT RESPONSIBILITY PLEDGE FOR FOLLOW-UP CARE

Patient Name: ______________________________________ Date: ___________________

I hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by Dr. Sadler are followed completely in order to increase the likelihood of a positive and healthy treatment and outcome.

I acknowledge and understand that if Dr. Sadler prescribes medicine to me that the proper taking of such medicine shall be my (or my guardian's) sole responsibility. I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my physician.

I understand that if Dr. Sadler refers me to see another physician or receive another test including, but not limited to, a blood test, MRI or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment and outcome. I understand that it is not possible for any person in this office to constantly follow up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand it is solely my responsibility to follow up on any of the medical advice given by any medical personnel in this office and any health outcome from my failure to follow the advice of my physicians should be expected.

Signature: ____

Relationship to Patient: ____