PATIENT DEMOGRAPHIC AND HISTORY

PATIENT INFORMATION **(Please Print)** **Today's Date: ___/___/___**

Name: ____

Mailing Address: ____
City/State/Pincode_________________________

Home phone _________________ Work Phone ____________________Cell Phone _____________________

Date of Birth: ___/___/___ Marital Status: __________ Age:_____ Sex:_____

INSURANCE INFORMATION

Primary Insurance Co. Name_________________________

Responsible Party: ☐ Self ☐ Spouse ☐ Parent

Name of Insured___________________________________

Address of Insured (if different)______________________

____

Date of Birth of Insured___________________________

Employer Name_________________________________

Relationship of patient to Insured___________________

Emergency Contact ____________________________ **Relationship**__________________ **Phone**___________________________

Can we discuss your medical conditions with other members of your family household? Yes No Specify_____________________

Primary Physician_________________________________ **Referring Physician** __________________________________

Phone #: ____ **Phone #**: ____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected.

Your signature below signifies your understand and willingness to comply with this policy.

Patient or Responsible Party Signature____ Date_____/_____/_____

If patient is a minor, print name of responsible party ____ Relationship _______________

Delhicolorectal Surgery
Dedicated Colorectal Service

Privacy Policy Acknowledgement Form

The Notice of Privacy Practice for the office of Dr. Sheikh Mohammad Taha Mustafa is available for your review at the front desk and on our website at http://www.delhicolorectal.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1- Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office of Sheikh Mohammad Taha Mustafa.

____ ____________________________

Patient Name Date

____ ____________________________

Date of Birth MRN **(Office use)**

Section 2- Notification and Emergency Designee

I give permission to Dr. Sheikh Mohammad Taha Mustafa and staff to perform the following duties in an effort to maintain continuity of care. Confirm/revise my appointment times by calling by home, business, and any other designated phone number

☐YES ☐NO

Leave message of normal test results on my home answering machine or with a specified family member ☐YES ☐NO

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointment and test results:

____

Designated Person Contact Number

I understand the information provided to me in the privacy notice and I have indicated my response to the questions in each section

____ __________________________

Patient (or Guardian) Signature and Phone Number Date

Dr. Sheikh Mohammad Taha Mustafa

Office Policies

1. It is the patient's responsibility to check to see if we are in-network.
2. You are responsible for knowing the policies of your insurance, such as co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination, etc.
3. Co-pays and self-pay procedures are due at the time of service, no exceptions.
4. Each scheduled appointment in our office is considered an office visit and will be charged to you or your insurance.
5. If a procedure is performed, it is an additional charge to your insurance.
6. If you are scheduled for a procedure it is your responsibility to make an appointment with your primary doctor for medical clearance. You are responsible to obtain your bowel prep and start it as instructed.

____ __________________________

Patient Signature Date

____

Patient Name

Delhicolorectal Surgery
Dedicated Colorectal Service

HISTORY (PAGE 1 OF 3 – *PATIENT TO COMPLETE*)

Date: ______________

Chief Complaint:____

How long have you had this complaint?____

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright red	Dark red
If yes, is the blood mixed with the stool or not mixed with the stool?	Mixed	Not mixed
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No
Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No
Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
In mothers, did you have birthing trauma that required stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No
If yes, what is the location?____________________________________		
Has anyone in your family had colon cancer at age less than 50?	Yes	No
Has anyone in your family had colon polyps?	Yes	No
Has anyone in your family had more than 10 colon polyps?	Yes	No
Do you need antibiotics prior to dental procedures?	Yes	No

Age ____________________ Height _____ Weight_____

Date of birth ______________ Sex_____ M _____ F

HISTORY (PAGE 2 OF 3 – *PATIENT TO COMPLETE*)

Past Medical History (place an X in the box next to your associated medical conditions)

☐	Diabetes	☐	High cholesterol	☐	Crohn's disease
☐	Asthma	☐	High blood pressure	☐	Ulcerative Colitis
☐	Emphysema	☐	Irritable bowel	☐	Colon polyps
☐	Arthritis	☐	Stomach ulcer	☐	Colon cancer
☐	Migraines	☐	Kidney stones	☐	Breast cancer
☐	Anxiety	☐	Enlarged prostate	☐	Uterine cancer
☐	Depression	☐	Abnormal heart rhythm	☐	HIV
☐	Hepatitis	☐	Heart valve damage	☐	Prostate cancer
☐	Diverticulosis	☐	Heart murmur	☐	Glaucoma
☐	Fibromyalgia	☐	Heart attack	☐	Stroke
☐	Liver disease	☐	Anemia	☐	Blood clots
☐	Rheumatic Fever	☐	Chronic back pain	☐	Kidney disease

Other

Previous Surgeries____

Medications (please include name, dose, and when taken)

Any Allergies? (List the medication or substance *and* your reaction. Include seasonal and food allergies)

Are you taking Aspirin?	Yes	No	Are you taking Plavix?	Yes	No
Are you allergic to latex?	Yes	No	Are you allergic to peanuts?	Yes	No
Are you allergic to IV dye?	Yes	No	Are you allergic to shellfish?	Yes	No

Social History

Do you smoke?	Yes	No	Do you drink alcohol?	Yes	No

How many years? _______ daily? Yes No
How many packs per day? _______

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HISTORY (PAGE 3 OF 3 – *PATIENT TO COMPLETE*)

Family History (please specify which family member had any of the following conditions)

Colon polyps______________________________
Ulcerative colitis___________________________
Familial polyposis__________________________
Uterine cancer_____________________________
Heart disease______________________________

Colon cancer________________________________
Crohn's disease______________________________
Breast cancer________________________________
Diabetes____________________________________
Strokes_____________________________________

Review of Systems

Eyes:

Have your eyes turned yellow?	Yes	No	Do you have glaucoma?	Yes	No

Head, ears, nose, throat and neck:

Do you have loose teeth?	Yes	No	Any frequent nose bleeds?	Yes	No
Any chronic sinus problems?	Yes	No	Do you have sleep apnea?	Yes	No

Cardiac:

Do your legs ever swell up?	Yes	No	Does your heart ever flutter?	Yes	No
Do you have chest pain?	Yes	No	Do you ever get light-headed?	Yes	No

Lungs:

Do you get short of breath?	Yes	No	Do you have a chronic cough?	Yes	No

Gastrointestinal:

Have you been nauseated recently?	Yes	No	Are you constipated?	Yes	No
Have you been vomiting recently?	Yes	No	Have you been having diarrhea recently?	Yes	No

Genitourinary:

Do you urinate often during the night?	Yes	No	Do you have blood in the urine?	Yes	No
Do you get urinary infections?	Yes	No	Any pain/burning when you urinate?	Yes	No

Neurologic:

Do you have headaches?	Yes	No	Are you sensitive to light?	Yes	No
Any recent slurring of your speech?	Yes	No	Have you ever been temporarily blind?	Yes	No

Integuments:

Any skin ulcers?	Yes	No	Any breast pain or masses?	Yes	No
Dry skin?	Yes	No	Any unusual rashes?	Yes	No

Psychiatric:

Feeling down?	Yes	No	Hearing voices?	Yes	No	Trouble concentrating?	Yes	No

Endocrine:

Gaining weight?	Yes	No	Losing weight (not intentional)?	Yes	No

Hematologic:

Bleeding problems?	Yes	No	Prior blood clots?	Yes	No	Sickle cell disease?	Yes	No

Musculoskeletal:

Difficulty walking?	Yes	No	Do your joints hurt?	Yes	No

Have you had any of the following tests? (If yes give the approximate date.)

Flexible sigmoidoscopy Yes No Date: ________

If yes, by whom?__________________________________

Barium enema Yes No Date: ________

Colonoscopy Yes No Date: ________

If yes, by whom?__________________________________

Cat scan of the abdomen Yes No Date: ________