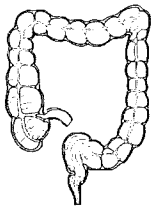


SAN DIEGO COLON AND RECTAL SURGEONS

Colon & Rectal • Laparoscopic Surgery

9834 Genesee Avenue • Suite 201 • La Jolla, California 92037 • Tel: 858.558.2272 • Fax: 858.558.2285 • www.sdcolonrectal.com

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

NAME ☐Mr. ☐Mrs. ☐Ms. _____ SOCIAL SECURITY # _____

LAST FIRST MIDDLE INITIAL DRIVERS LICENSE _____

SEX _____ MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐SEPARATED ☐WIDOWER ☐MINOR

BIRTHDATE _____ AGE _____ ETHNICITY _____ HOME PHONE _____

HOME ADDRESS _____ WORK PHONE _____

STREET ADDRESS CITY STATE ZIP

EMPLOYED BY _____ CELL PHONE _____

LAST FIRST MIDDLE INITIAL

OCCUPATION _____

SPOUSE/PARENT _____

LAST FIRST MIDDLE INITIAL

SPOUSE/PARENT PHONE # _____

PHARMACY _____

WHO REFERRED YOU TO THIS OFFICE? _____

LAST FIRST MIDDLE INITIAL

WHO IS YOUR PRIMARY PHYSICIAN? _____

DO YOU WANT CORRESPONDENCE BY ☐ MAIL ☐ E-MAIL EMAIL ADDRESS: _____

☐ PATIENT PORTAL

MEDICAL INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO. _____

POLICY NUMBER _____ SSN: _____

POLICY HOLDER'S NAME (if different) _____ GROUP # / NAME _____

NAME OF SECONDARY INSURANCE CO _____

POLICY NUMBER _____

POLICY HOLDER'S NAME (if different) _____ GROUP # / NAME _____

EMERGENCY CONTACT

NAME OF RESPONSIBLE PARTY _____ HOME PHONE _____

WHAT IS THEIR RELATION TO THE PATIENT _____ CELL PHONE _____

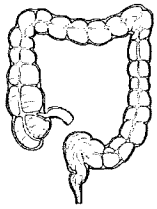
PLEASE SIGN AND RETURN TO RECEPTIONIST

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO SAN DIEGO COLON AD RECTAL SURGEONS, INC. ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE X _____ DATE _____

IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENT

*NOTE: Please notify us if any of the above information changes during the course of your treatment.



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HISTORY & PHYSICAL

Patient's Name: _____

Date: _____

Age: _____ Sex: _____ Referred by: _____

For Doctor's use only

BP	Pulse	Weight	Height

We sincerely appreciate your taking the time to complete the following questions about your personal medical history before seeing the doctor. This information will be of significant importance in providing for your personal health care.

CHIEF COMPLAINT

List the problems which have led you to seek medical help now, and approximately when each began.

	PROBLEM	DATE OF ONSET
1.		
2.		

PAST MEDICAL AND SURGICAL HISTORY (Attach separate sheet if necessary)

List chronologically the surgery you have had, indicating the nature of each operation and where and when it was done.

OPERATION	HOSPITAL & CITY	DATE

Have you ever been seriously injured? (If so, give details) _____

_____

List all medical problems for which you see or have seen a doctor (most significant first).

MEDICAL PROBLEM	DOCTOR SEEN	DATE

List chronologically all hospitalizations not already mentioned.

REASON FOR HOSPITALIZATION	HOSPITAL & CITY	DATE

Have you ever had any of the following? (If so, give date and details)

Heart Attack _____
Palpitations _____
Chest Pain (Angina) _____
High Blood Pressure _____
Lung Disease/Pneumonia _____
Diabetes _____
Asthma _____
Intestinal Bleeding _____
AIDS/HIV Infection _____

Cancer _____
Prolonged Bleeding _____
Hepatitis/Jaundice _____
Alcoholism _____
Kidney Disease _____
Stroke _____
Arthritis/Gout _____
Other Illness _____
Nervous Breakdown _____

(OVER)

Patient's Name: _____ Date: _____

CURRENT MEDICATIONS

List all the medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate and complete. (Do NOT neglect aspirin and other pain medicines, hormones; contraceptive, water, diet, nerve, sleeping, iron or vitamin pills). Include list of non-prescription medications (ask for additional sheet if needed).

CURRENT MEDICINE	STRENGTH OF DOSE	HOW OFTEN TAKEN	START DATE

MEDICATION ALLERGIES

NAME OF MEDICATION	YES	NO	TYPE OF REACTION AND WHEN
Penicillin			
Sulfa			
Iodine			
Other			

HABITS

TOBACCO

Do you smoke now? _____ If yes, for how long? _____ How many cigarettes per day? _____

If you do not smoke now, did you smoke in the past? _____

If so, when did you Start?_____ Stop?_____ How many cigarettes per day?_____

per day? _____

ALCOHOL

How many alcoholic beverages do you drink per day? _____

CAFFEINE

PERSONAL HISTORY

Where were you born? _____ How long have you lived in California? _____

Have you lived or travelled outside the U.S.? _____ When: _____ Where: _____

What type of work do you do on a daily basis (e.g. desk work, house cleaning, gardening, heavy manual labor, etc.)? _____

Are you married?: _____ For how long? _____ Have you any children? _____ How many? _____

FAMILY HEALTH

Please give the following information about the health of your immediate family:

RELATION	Age	Age at Death	STATE OF HEALTH OR CAUSE OF DEATH	Colon Cancer or Polyps
MOTHER				
FATHER				
BROTHERS AND SISTERS				
SPOUSE				
CHILDREN				

Have any blood relatives ever had any of the following? (If so, indicate relationship).

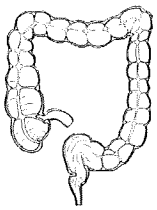
Diabetes: _____ ☐ Cancer: _____ ☐ High blood pressure: _____ ☐

Rheumatoid arthritis: _____ ☐ Blood disease: _____ ☐ Any obscure or unusual disease: _____ ☐

Tuberculosis: _____ ☐ Allergies: _____ ☐ Psychiatric disease or nervous breakdown: _____ ☐

Gout: _____ ☐ Alcoholism: _____ ☐ A disease which "runs in the family": _____ ☐

Lung Disease: _____ ☐ Asthma: _____ ☐ Hay fever: _____ ☐



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GASTROINTESTINAL Systems Review

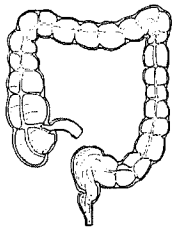
Patient's Name: _____

Date: _____

Referred by: _____

Answer all questions. If you do not know the answer or understand the question, insert a question mark. LEAVE NO BLANKS!

		YES	DATE OF ONSET	NO
1.	Have you ever been treated for hemorrhoids?			
2.	Do you have hard bowel movements?			
3.	Do you have diarrhea?			
4.	Do you have a bowel movement daily?			
	Less Frequently?			
5.	Are your bowel movements painful?			
6.	Do you feel a lump when you wipe?			
7.	Do you have problems cleaning after a bowel movement?			
8.	Do you soil your underclothing?			
	with blood?			
	with pus?			
9.	Have you ever had anal intercourse?			
10.	Do you have itching?			
11.	Do you use a laxative regularly?			
	Type _____			
12.	Do you have rectal bleeding?			
	When did it begin? _____			
	Is the blood bright red?			
	Is the blood on the stool?			
	Is the blood mixed with the stool?			
13.	Have you ever had rectal surgery?			
	Type _____			
	Date _____			
14.	Have you ever had a polyp?			
15.	Have you ever had colitis?			
16.	Do you ever have problems controlling your bowel movements?			
17.	Have you ever had a barium enema (lower GI series)?			
	If so, when _____			
18.	Have you ever had a colonoscopy or other exam?			
	If so, when _____			
19.	Has anyone in your immediate family ever had intestinal cancer?			
	If so, who and at what age? _____			



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jworsey@sdcolonrectal.com

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FACS

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FEMALE Review of System **Patient Name:** _____ **Date:** _____

Constitutional ☐ **Normal**

☐Y ☐N Fever	☐Y ☐N Feeling Poorly (Malaise)	☐Y ☐N Recent Weight Gain (_____ lbs)
☐Y ☐N Chills	☐Y ☐N Feeling Tired (Fatigue)	Recent Weight Loss (_____ lbs)

Cardiovascular ☐ **Normal**

☐Y ☐N Chest Pain	☐Y ☐N Heart Rate is Fast	☐Y ☐N Claudication (Leg Pain with Exercise)
☐Y ☐N Palpitations	☐Y ☐N Heart Rate is Slow	☐Y ☐N Lower Ext Edema

Respiratory ☐ **Normal**

☐Y ☐N Shortness of Breath	☐Y ☐N Cough	☐Y ☐N Orthopnea (Shortness of Breath while lying flat)
☐Y ☐N Wheezing	☐Y ☐N Dyspnea (Shortness of Breath - SOB)	☐Y ☐N PND (Sudden Onset of SOB While Sleeping)

Gastrointestinal ☐ **Normal**

☐Y ☐N Abdominal Pain	☐Y ☐N Constipation	☐Y ☐N Heartburn
☐Y ☐N Vomiting	☐Y ☐N Diarrhea	☐Y ☐N Melena (Black Stool)

Genitourinary ☐ **Normal**

☐Y ☐N Dysuria (Painful Urination)	☐Y ☐N Pelvic Pain	☐Y ☐N Vaginal Discharge
☐Y ☐N Incontinence	☐Y ☐N Dysmenorrhea (Painful Periods)	☐Y ☐N Abn Vaginal Bleeding

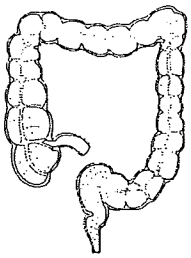
Integumentary ☐ **Normal**

☐Y ☐N Skin Lesions	☐Y ☐N Itching (Pruritus)	☐Y ☐N Dry Skin
☐Y ☐N Rash	☐Y ☐N Change In A Mole	☐Y ☐N An Unusual Growth

Neurological ☐ **Normal**

☐Y ☐N Confused	☐Y ☐N Dizziness	☐Y ☐N Limb Weakness (Paresis)
☐Y ☐N Convulsions	☐Y ☐N Fainting (Syncope)	☐Y ☐N Difficulty Walking

Other Symptoms: _____



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jworsey@sdcolonrectal.com

Keith A. Beiermeister, *MD*
FACS

INSURANCE WAIVER

I have been informed that:

__X__ It is my responsibility to verify that Dr. Worsey/Dr. Beiermeister are in fact contracted providers with my insurance plan. (Tax ID: 330966940)

__X__ Dr. Worsey/ Dr. Beiermeister are not contracted with Medi-Cal insurance. I am aware Medi-Cal will NOT be billed. (If) I have Medi-Cal, I am personally responsible for paying any balance not paid by my primary insurance.

_____ My insurance identification card is not available; it is my responsibility to provide correct and accurate insurance information to my doctor. If I do not provide the necessary information, I understand I will be responsible for payment.

_____ I am using my POS/PPO option of my insurance plan.

_____ I am a self-pay patient for my visit(s).

I understand that due to the reason provided above, my insurance may:

a) Not pay anything.
b) Pay at a lesser percentage.
c) Take out a deductible (for services provided by my physician or for any lab tests ordered from an outside lab).

As out of network insurance coverage varies greatly from plan to plan it is impossible for us to determine what your level of coverage will be. We strongly recommend you call your insurance and ask them directly. The service and procedure codes can be given to you to help in this. We also recommend you get a specific dollar amount based upon the information we provide, preferably in writing. We will help you with this so that there are no surprises when your insurance company determines your benefits.

I understand that I am responsible for payment of any services provided.

PATIENT NAME (print) _____

PATIENT SIGNATURE _____ DATE:_____

PATIENT CONTACT INFORMATION CONSENT FORM

For The office(s) of:
Medical Group/Physician Name: San Diego Colon and Rectal Surgeons
Address: 9834 Genessee Avenue, Ste 201 La Jolla, CA 92037
Phone Number: 858-558-2272

In general, the HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or alternative means of communicating PHI, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner **(please check all that apply).**

Home/Cell phone:

- Authorized to leave a detailed message on home/cell phone_____
- Authorized to leave a message with call back number only_____

Work:

- Authorized to leave a detailed message on work phone_____
- Authorized to leave a message with call back number only_____

Written Communication:

- Ok to mail to my home address_____
- OK to mail to my work/office address_____
- OK to fax to _____
- Other_____

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be in effect until which time it is revoked.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

SAN DIEGO COLON AND RECTAL SURGEONS

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Keith A. Beiermeister, MD
FACS, FASCRS

CANCELLATION
&
NO SHOW POLICY

Because our practice has become very busy our patients are having to wait increasing lengths of time for appointments. Unfortunately, this problem is exacerbated when patients cancel their appointment on the day they are to be seen or simply fail to show up without informing us.

In an attempt to accommodate our patients we are therefore instituting a cancellation/no-show policy as follows:

Cancellations or rescheduling of appointments must be done 24-business hours prior to your scheduled appointment so that we can try to use that appointment to see another patient.

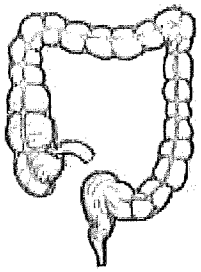
For example, a Wednesday appointment would need to be canceled or changed on Tuesday and a Monday appointment would need to be canceled or changed on the preceding Friday.

If this policy is not followed then a $50 no show/cancellation fee will be required before another appointment can be made. We understand there are genuine unforeseen emergencies and will amend this policy on a case-by-case basis.

This policy is designed to serve our patients better by allowing them to be seen as soon as possible.

I have read and understand the above cancellation policy

(SIGNATURE) (DATE)



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FLEXIBLE FIBEROPTIC SIGMOIDOSCOPY

A flexible fiberoptic sigmoidoscopy is a diagnostic examination which permits visualization of the last two feet of the intestinal tract. The extent of anorectal problems can be better assessed with this screening tool.

A flexible fiberoptic sigmoidoscopy is much more comfortable than in the past when more rigid scopes were used. Preparation for the examination is quite simple; administer one Fleet's enema two hours before travel time to the office followed by one Fleet's enema taken one hour prior to travel time. It is **NOT** necessary to alter your diet the day before, or on the day of your examination. It is important **NOT** to take additional laxatives in an attempt to better clean the colon.

The sigmoidoscope is introduced into the anus. A small amount of air is insufflated into the colon in order to facilitate visualization of the intestinal lining. This occasionally causes some mild cramps and a feeling of urgency (similar to that sometimes experienced prior to a bowel movement). This examination is typically completed in less than five minutes and does not commonly cause pain. If an abnormality is found, a biopsy can sometimes be obtained through the sigmoidoscope. Since there are no pain fibers in the intestinal tract, there is no discomfort associated with a biopsy.

The instrument is compulsively cleaned between examinations, and there is virtually no chance of transmission of communicable diseases. A small potential for bleeding or perforation does exist; however, in more than 20 years of practice, this has not occurred.

CONSENT FOR EXAMINATION AND TREATMENT

I have read and understand the above information. I consent to proceed with the understanding that I will have the opportunity to ask my doctor any questions regarding this procedure before, during, and after the examination.

I hereby authorize my doctor to perform a consultation and examination which may include an endoscopic evaluation of the anus, rectum, and left side of the colon. Further, I authorize biopsy and/or removal of any abnormalities that are encountered during the endoscopic evaluation.

THIS CONSENT SHALL REMAIN IN EFFECT FOR SUBSEQUENT VISITS FOR **ONE YEAR** FROM THE DATE OF SIGNATURE

_____

Patient Name (***Please Print***)

_____ _____

Patient Signature (***Please sign in presence of office staff***) Date

_____ _____

Witness Signature Date

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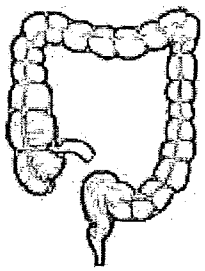

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Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have received a copy of San Diego Colon and Rectal Surgeons Notice of Privacy Practices.

_____ _____

Signature of patient Date