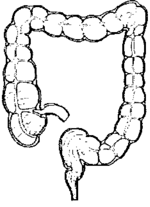

SAN DIEGO COLON AND RECTAL SURGEONS

Colon & Rectal • Laparoscopic Surgery

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PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

NAME ☐Mr. ☐Mrs. ☐Ms. ____________________ LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY # ____________________

DRIVERS LICENSE ____________________

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

BIRTHDATE ____________ AGE ________ ETHNICITY ____________

HOME PHONE ____________________

HOME ADDRESS ____________________ STREET ADDRESS CITY STATE ZIP

WORK PHONE ____________________

EMPLOYED BY ____________________ LAST FIRST MIDDLE INITIAL

CELL PHONE ____________________

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 ____________________

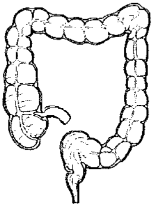
PLEASE SIGN AND RETURN TO RECEPTIONIST

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: __________
Rheumatoid arthritis: __________
Tuberculosis: __________
Gout: __________
Lung Disease: __________
Cancer: __________
Blood disease: __________
Allergies: __________
Alcoholism: __________
Asthma: __________
High blood pressure: __________
Any obscure or unusual disease: __________
Psychiatric disease or nervous breakdown: __________
A disease which "runs in the family": __________
Hay fever: __________

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GASTROINTESTINAL Systems Review

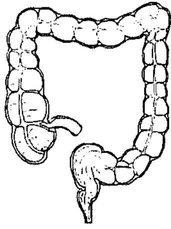
Patient's Name: ______________________

Date: ______________________

Referred by: ______________________

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

	Question	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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MALE 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	Hesitancy	❒ Y	❒ N	Genital Lesion
❒ Y	❒ N	Incontinence	❒ Y	❒ N	Nocturia (Urination at Night)	❒ Y	❒ N	Impotence

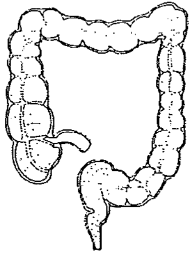
Integumentary ❒ **Normal**

❒ 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:

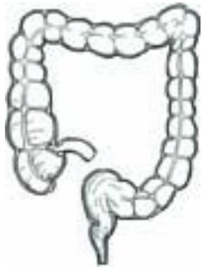
- Ok to mail to my home address_______________________________________
- OK to mail to my work/office address__________________________________
- OK to fax to ____
- Other____

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



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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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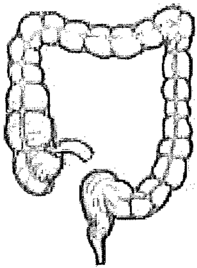

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FLEXIBLE FIBEROPTIC SIGMOIDOSCOPY

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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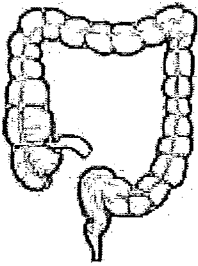

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Acknowledgement of Receipt of Notice of Privacy Practice

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

____
Signature of patient

____
Date

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