SAHAI SURGICAL
GENERAL COLORECTAL ONCOLOGY

Patient Information

****Please write your name EXACTLY how it is shown on your insurance card****

Last Name_____ First Name_____ MI_____ Date of Birth _____

Gender_____ Marital Status (Married, Single, Divorced, Separated, Domestic Partnership) _____

Address_____ City_____ State_____ Zip_____

Primary Phone_____**Circle Type** (Home, Mobile, Work, Alternate)

Secondary Phone_____ **Circle Type** (Home, Mobile, Work, Alternate

Email Address_____

Occupation_____ Employer_____ Phone_____

Associated Providers & Pharmacy Information

Primary Care Provider_____ Referring Physician_____

Phone_____ Phone _____

Pharmacy Name_____ Crossroads_____

Insurance Information

Primary Insurance_____ Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

Secondary Insurance_____ Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

Emergency Contact

Name _____ Phone_____

Relationship to Patient_____

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Date_____

Name_____

Date of Birth _____

Referring Physician_____

Chief Complaint

_____

_____

_____

Past Medical History	Yes	No
Heart Disease		
Hypertension		
High Cholesterol		
Diabetes Type: _____		
Stroke/ TIA		
COPD		
Cancer: _____		
Bleeding Disorder		

Surgical History	Date

Date of Last Colonoscopy: _____

Current Medication	Dose

Medication Allergies	Reaction

Social/ Personal History	
Tobacco	Never____ Former____ Current____
If Current, how often?	
Alcohol	Never____ Former____ Current____
Drug Use	Never____ Former____ Current____
Pregnant	Yes_____ No_____

Family Medical History	Illness
Father Living_____ Deceased_____	
Mother Living_____ Deceased_____	
Siblings How Many_____	

Please check any of the following that has occurred in the past year.

	Yes	No		Yes	No
Headaches			Incontinence		
Vision Changes			Depression		
Hearing Loss			Chest Pain		
Shortness of Breath			Anxiety		
Cough			Bleeding Problems		
Stomach Ulcer			Chills		
Blood in Stool			Fever		
Diarrhea			Loss of Appetite		
Constipation			Night Sweats		
Bladder/ Kidney Infection			Skin Rash		
Joint Pain					
Stiffness					
Swelling					
Dizziness					
Thyroid Disease					
Anemia					

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Alcohol Misuse/ Abuse

Have you had a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If YES: How often did you have a drink containing alcohol in the past year?

- ☐ Monthly or Less (1 point)
- ☐ 2-3 times a month (2 points)
- ☐ 4-6 times a month (3 points)
- ☐ 7-more times a month (4 points)

How many drinks did you have on a typical day when drinking in the past year?

- ☐ 1 or 2 (0 points)
- ☐ 3 or 4 (1 point)
- ☐ 5 or 6 (2 points)
- ☐ 7 to 9 (3 points)
- ☐ 10 or more (4 points)

How often did you have six or more drinks on one occasion in the past year?

- ☐ Never (0 points)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Points _____

Interpretation

☐ Positive

☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use.)

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive

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Tobacco Use

Additional Findings: Tobacco (Please check those that apply)

☐ Chews

- ☐ Fine Cut
- ☐ Loose Leaf
- ☐ Plug
- ☐ Twist

☐ Trivial Cigarette Use (less than 1 daily)

☐ Light Cigarette Use (1-9 daily)

☐ Moderate Cigarette Use (10-19 daily)

☐ Heavy Cigarette Use (20-39 daily)

☐ Very Heavy Cigarette Use (40+)

☐ Chain Smoker

☐ Pipe Smoker

☐ Rolls Own Cigarettes

☐ Snuff User

☐ Moist Powdered Tobacco

Are you a:

☐ Current Smoker

☐ Former Smoker

☐ Never Smoker

☐ Current everyday Smoker

☐ Current Some Day Smoker

☐ Smoker, status unknown

☐ Unknown if ever smoked

☐ Light Tobacco Smoker

☐ Heavy Tobacco Smoker

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Patient Consent Form

_____
Initial

Insurance

Our office and providers are contracted with most insurance carriers. Upon scheduling we will request for insurance information to determine the likely hood of being contacted with your carrier. Due to the constant change and updates on carrier plans and networks, we may not be able to determine that every individual plan is contracted. Ultimately, it is the patient's responsibility to know their health plan benefits and network before seeking any services.

_____
Initial

Co-Payments, Deductibles and Account Balances

We accept cash, personal checks, Visa, Master Card, Discover and American Express. Co-payments will be collected at the time of service at each appointment. For any deductible balances or applicable account balances we can provide payment plans if needed. We also offer the option for payments to be called in or made on our website.

_____
Initial

No-Shows, Cancellations and Reschedules

Our office requires a **24-hour notice** for cancelations and reschedules for **office appointments** and a **72-hour notice** for cancelations and reschedules for **procedures**. Failure to provide proper notice can be subject to a $50 fee. Our office allows a maximum of 3 no-shows, cancelations and/or reschedules within a 60-day period, failure to comply can be subject to a practice discharge.

I acknowledge that I have read and agree to the office policy.

I hereby assign my medical benefits to be utilized by the provider services are rendered under.

I hereby authorize the release of my medical information to the insurance companies to process claims, to my referring physician and to any physician involved in my care.

_____ _____

Patient/Guardian (Please Print) Date

_____ _____ _____

Patient/Guardian Signature Relationship to Patient Patient Date of Birth

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it has been cancelled.

If there are any changes to your payment card preference, please notify us to fill out a new form.

Credit Card Information
Card Type: ☐VISA ☐Mastercard ☐Discover ☐AMEX ☐Other _____
Card Holder Name (as shown on card): _____
Card Number: _____
Expiration Date: _____ /_____
Billing ZIP Code: _____
CVC: _____

I, _____ authorize **Sahai Surgical Specialists** to charge my credit card above for agreed upon amount towards my account balance. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐ YES or ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(Please Print Name)

Signature: _____ Date: _____

AALOK K. SAHAI, M.D.
ROHIT K. SAHAI, M.D.
JESSICA FLADEN, PA
963 N McQueen Road
Chandler, Arizona 85225
Office: 480-646-8440 Fax: 480-646-8441

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that Sahai Surgical Specialists release my medical records to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I hereby authorize and request my medical records to be released to Sahai Surgical Specialists from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I authorize to release the following information:

☐ History & Physical ☐ Lab Reports ☐ XR/MRI/CT Scan/EMG ☐ Discharge Summaries

☐ Consultations ☐ Pharmacy/Medication Profile ☐ All Available Records

Patient Name: _____ DOB: _____
Print Name Please

Patient Signature: _____ Date: _____

When requesting release of records, please allow us 7-10 days for processing – Thank you