PATIENT REGISTRATION FORM

Patient Name: ______________________________ Social Security Number: ________ - ________ - ________

Date of Birth: _____/_____/_____ Age: ______ Sex: M / F / T / Other Married / Single / Partner / Divorced / Widow(er)

Phone: (______) ________ - ________ Email: ______________________________

Address: ____
(Street) (City/State/Zip)

Preferred Pronoun: ________________ Race: ____________ Ethnicity: ________________

Employer Name: ______________________________ Employer Phone: (______) ________ - ________

Primary Care Physician: ____
(Name) (Phone)

Pharmacy: ____
(Name) (Address) (Phone)

How did you hear about our Practice? ______________________________

....

Person responsible for bill (*Complete <u>only</u> if different from patient*)

Guarantor Name: ______________________________ Guarantor Phone: (_____) ________ - ________

Relationship to Patient: (please check): ( ) self ( ) spouse ( ) parent ( ) partner Date of Birth: _____/_____/_____

Address: ____
(Street) (City/State/Zip)

....

Emergency / Alternate Contact

Name: ______________________________ Relationship: ______________________________

Home Phone: (______) ________ - ________ Alternate Phone: (______) ________ - ________

....

PRIMARY INSURANCE INFORMATION

Plan Name: ______________________________ I.D. Number: ______________________________
Address: ______________________________ Group Number: ______________________________
Policy Holder's Name (write SELF if patient): ______________________________
Policy Holder's Social Security Number: ________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION

Plan Name: ______________________________ I.D. Number: ______________________________
Address: ______________________________ Group Number: ______________________________
Policy Holder's Name (write SELF if patient): ______________________________
Policy Holder's Social Security Number: ________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____

....

I acknowledge that I am ultimately financially responsible for payment whether or not services are covered by my insurance. I acknowledge that any out of pocket costs (ie; deductible, coinsurance, copayment) incurred from services rendered by Dr. Elie Schochet are my responsibility. By signing below, I understand and comply with the above statements regarding my financial responsibility to South Florida Colorectal Institute, Elie Schochet, M.D.

Signature: ______________________________ **Date:** ________________

PATIENT HISTORY FORM

Patient Name: ____

What type of complaint or disease is the reason for requesting this visit?

____

Habits: Do you smoke? No_____Yes_____ If yes, how many packs per day? ______________
If you have quit, how long ago? ______________

Do you use alcohol? No_____Yes_____ If yes, how often do you drink? ______________
If you have quit, how long ago? ______________

Do you use marijuana? No_____Yes_____ If yes, how often? ______________
If you have quit, how long ago? ______________

PAST MEDICAL HISTORY:

Please list other diseases/conditions from which you **currently** suffer:

____

____

Please list other medical conditions from which you have suffered **in the past**:

____

____

Please list any surgeries (operations), reason for the surgery, and date of surgery:

____

____

____

____

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

____

____

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your **blood relatives**

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Cancellation and No-Show Policy

Our goal is to provide quality individualized medical care in a timely manner. No Shows create an inconvenience for the practice and prevent scheduling of other patients who need access to medical care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

Please call our office by 3:00 pm on the business day prior to your scheduled office appointment to notify us if you need to reschedule or cancel. Office appointments which are rescheduled or cancelled **without** advanced notice will be subject to a **$25.00 Late Cancellation Fee**. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment

______________________________ ____________________
Signature of Patient Date

______________________________ ____________________
Signature of Witness Date

COLORECTAL SURGERY CLINIC
OF TAMPA BAY

Lourdes T. Santiago, MD
Board-Certified, General Surgery
Fellowship Trained, Colorectal
(727) 483-9188
Fax (727) 412-8432
1305 S. Fort Harrison Avenue, Bldg A • Clearwater, FL 33756

Informed Consent for Laparoscopic Inguinal Hernia Repair

1. What do I need to know about this condition?
A hernia, sometimes referred to as a rupture, occurs when a part of an internal organ, sometimes the bowel, pushes through weak point in the abdominal wall.

Inguinal hernia
An inguinal hernia is the most common type of hernia, and twenty times more common in men than in women. It is likely that about 1 in 20 men will develop an inguinal hernia. The inguinal canal is in the groin. The first signs of a hernia are pain and/or a lump.

2. What do I need to know about this procedure?

Laparoscopic repair

This procedure is an inguinal hernia repair by a laparoscopic (key hole) technique using small incisions and a telescope. Laparoscopy or key-hole surgery is performed under general anaesthetic. Small cuts are made in the abdomen. Instruments are pushed into the holes and carbon dioxide gas is blown into the abdomen to lift the abdominal wall away from the internal organs so that the surgeon has a good view. A nylon or prolene mesh is sewn and/or stapled in place over the weak area. The instruments are removed and the gas is allowed to escape before stitching or stapling the cuts together.

3. What are the benefits of having this procedure?
The pain and lump will be relieved by the surgery. Planned surgical treatment of a hernia is much safer than leaving the hernia until an emergency happens.

4. What are the risks of not having this procedure?
The hernia will probably get bigger. Inside, the bowel may become trapped and blocked or gangrenous (that part of the bowel dies). This can be very dangerous and will need emergency treatment. Treatment may require extensive surgery to the bowel.

5. What are some alternative treatments?
Truss
A truss may be worn which applies support to the weak area. The truss is not a cure and can be uncomfortable. It may cause pressure sores and is not always effective. The proper use of a truss requires medical advice.

6. Anaesthetic
This procedure will require a general anaesthetic. The anaethetist will give you information about the anaesthetic and the risks involved. If you have any concerns or questions, feel free to discuss these with him/her.

7. What are the risks of this specific procedure?

There are risks and complications with this procedure. They include but are not limited to the following:

Haematoma or seroma	A lump can develop at the site of the hernia caused by blood and/or fluid (seroma).	This usually settles after a few weeks, but may require drainage.
Ongoing pain or discomfort in groin.	One of the small nerves in the groin can be cut or caught in a stitch or scar causing long term burning and aching in the groin in 1 in 50. This may happen straight after surgery or months or years later.	
Change to testicle.	The testicle may sit a little higher in the scrotum after surgery. A change in physical appearance. Wound infection, the wound may become infected. The rate of risk is estimated at about 1% or 1 in 100.	

Infection	Infection can occur in the surgical site, or in a remote site.	This will require antibiotics and further treatment. Inform the healthcare team if you get a high temperature, notice pus in your wound, or if your wound becomes red or painful.
Wound infections.	An infection can develop in the surgical site.	Wound infections are usually treated with dressings and/or antibiotics.
Wound complications.	Possible bleeding into the wound after the surgery in 1 in 30. Swelling, bruising, blood stained discharge, which may cause pain, or become infected.	Treatment is usually antibiotics and/or drainage by further surgery.
Unsightly wounds.	The wounds may not heal normally. The scars can thicken and turn red and may be painful.	This is permanent and can be disfiguring. It is more frequent in recurrent hernias.
Bands of scar tissue – adhesions.	Bands of scar tissue can form inside the abdomen, which may cause bowel blockage and possible bowel damage.	Further surgery may be necessary.
Hernia recurrence	The hernia may come back in 1 in 30 to 1 in 100.	Further surgery to repair the hernia.
Hernias at the wound sites.	Hernias may form where instruments were passed into the abdomen. Increased risk in smokers. Smoking slows wound healing and affects the heart, lungs and circulation.	This may need further surgery. Giving up smoking before the operation will help reduce the risk.
Collapse of lung (atelectasis)	Small areas of the lung can collapse, increasing the risk of chest infection.	This may need antibiotics and physiotherapy and rarely ventilatory support.

Laparoscopic Gallbladder Removal & Bile Duct X-Ray Consent Form

Patient Name: _____ Date of Birth: _____

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. ________________________ to perform a **Laparoscopic Gallbladder Surgery (Cholecystectomy)** upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to ____________. I understand that the procedure or treatment can be described as follows: **Utilizing a small camera (laparoscope) inserted into the abdominal cavity my surgeon will view and remove the gallbladder via multiple small incisions (ports). The procedure may include an x-ray of the bile duct (cholangiogram) if deemed appropriate by the surgeon.**

This procedure will require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Partial or complete relief of symptoms of abdominal pain related to gallstone attacks, minimization of risks of further attacks, possible identification of retained gallstones, identification of abnormal anatomy or pathology that may contribute to symptoms.

While a cholecystectomy is often an effective treatment for symptomatic gallstones/biliary colic/gallbladder polyps/biliary, dyskinesia/chronic cholecystitis/acute cholecystitis/gallstone pancreatitis not all conditions, diseases or problems can be treated solely by cholecystectomy. Some symptoms may remain after successful surgery, and a possibility exists for the need of future medical or surgical interventions.

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

- Infection, (possibly requiring medication and/or surgery), bleeding (possibly requiring transfusion), injury to the liver, common bile duct or other internal structure, delayed recognition of an injury, possible need for re-operation or other intervention (medical or surgical), possible long-term dysfunction of the biliary system, possible need to convert to an open operation, possible need for hospitalization (short or long term), delayed recovery, possible change in bowel habits and/or digestion that may require medication (short or long term). Chronic pain, incisional hernia formation, infection, need for re-operation, hospitalization, short or long-term disability or death.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do

INFORMED CONSENT FOR COLON SURGERY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

________ ______________

Patient's Initials or Authorized Representative Date

I, ______________________________, hereby authorize Dr. ______________________and any associates or assistants the doctor deems appropriate, to perform upon me the following:

❑ Total Colectomy ❑ Subtotal Colectomy ❑ Hemicolectomy (Right / Left) ❑ Ostomy

❑ Ileostomy ❑ Colostomy ❑ Colorectal Anastomosis ❑ Sigmoidectomy

❑ Low Anterior Resection ❑ Total Proctectomy ❑ Abdominal Perineal Resection ❑ Rectopexy

❑ Other____

❑ Open ❑ Laparoscopic

Brief Description of Colon Surgeries

Total Colectomy: Removal of entire colon.

Subtotal Colectomy: Resection of part of the colon or resection of all of the colon without complete resection of the rectum.

Hemicolectomy: Right hemicolectomy—resection of the ascending colon. Left hemicolectomy—resection of the descending colon.

Ostomy: An artificial opening on the abdominal wall through which waste material passes out of the body from the bowel or urinary tract. A **colostomy** is an ostomy that specifically opens from the colon. A colostomy requires an appliance (odor-proof bag) to collect waste material. A colostomy closure, or **colorectal anastomosis** is surgery to close a previous colostomy.

Ileostomy: Involves bringing the ileum (the last portion of the small intestine) to the abdominal surface. When waste matter reaches the ileum it is liquid, so an appliance (odor-proof bag) is needed to collect

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

___________Foreign language (specify)

___________Sign language

___________Patient is blind, form read to patient

___________Other (specify)____

Interpretation provided by ____

(Fill in name of Interpreter and Title or Relationship to Patient)

_______________________________   _____________/______________

Signature (Individual Providing Assistance)   Date   Time