

Ohio Valley Colon & Rectal Surgeons, Inc.

James Waller, MD  
Deane Smith, MD  
Syam Chilukuri, MD  
Santiago Arruffat, MD

TODAY'S DATE: \_\_\_\_\_  
PT. NAME: \_\_\_\_\_  
CHART#: \_\_\_\_\_

**SOCIAL HISTORY:**

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
ADDRESS (Street) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(PO Box) \_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_  
PHONE (home) \_\_\_\_\_ PHONE (work) \_\_\_\_\_  
E-MAIL (home) \_\_\_\_\_ E-MAIL (work) \_\_\_\_\_  
CELL PHONE \_\_\_\_\_

OCCUPATION/SCHOOL \_\_\_\_\_ GRADE IN SCHOOL \_\_\_\_\_

MARITAL STATUS (circle one) S M D W RACE (optional) \_\_\_\_\_

Patient's Employer (or retired from) \_\_\_\_\_

Patient's Employer's ADDRESS \_\_\_\_\_

**IF MARRIED / IF A MINOR CHILD**

Spouse/Parent's NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
ADDRESS (Street) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_  
PHONE (home) \_\_\_\_\_ PHONE (work) \_\_\_\_\_  
CELL PHONE \_\_\_\_\_

Spouse/Parent Employer \_\_\_\_\_

Spouse/Parent Employer's ADDRESS \_\_\_\_\_

**INSURANCE HISTORY:**

Primary Insurance Co. \_\_\_\_\_ Secondary Insurance Co. \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member Name: \_\_\_\_\_

Person Responsible for Bill \_\_\_\_\_

**OHIO VALLEY COLON AND RECTAL SURGEONS, INC**

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APPT.DATE \_\_\_\_\_ TIME \_\_\_\_\_  
TODAY'S DATE \_\_\_\_\_  
DR. W / S / C / A CHART # \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Please complete **ALL** sections and **SIGN**. May use "N/A" if not applicable.

**NAME** \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_ **AGE** \_\_\_\_\_ **SEX** \_\_\_\_\_

**REFERRING PHYSICIAN** \_\_\_\_\_ **FAMILY PHYSICIAN** \_\_\_\_\_

(First name, Last name)

(First name, Last name)

**DO YOU SMOKE** \_\_\_yes \_\_\_no how many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

**DO YOU DRINK ALCOHOL?** \_\_\_yes \_\_\_no how often? \_\_\_\_\_ how much? \_\_\_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

**MEDICAL HISTORY:**

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

(Check all that apply to **YOU**, not your family)

- | yes   | no    |  |
|-------|-------|--|
| _____ | _____ | lung disease/asthma                    |
| _____ | _____ | high blood pressure                    |
| _____ | _____ | cancer, location _____                 |
| _____ | _____ | heart disease                          |
| _____ | _____ | stroke                                 |
| _____ | _____ | heart attack                           |
| _____ | _____ | arhythmia                              |
| _____ | _____ | diabetes, insulin dependent            |
| _____ | _____ | diabetes, <u>not</u> insulin dependent |
| _____ | _____ | diverticulosis                         |
| _____ | _____ | irritable colon                        |
| _____ | _____ | stomach ulcers                         |
| _____ | _____ | arthritis, rheumatoid, lupus           |
| _____ | _____ | heart murmur                           |

- | yes   | no    |                                   |
|-------|-------|-----------------------------------|
| _____ | _____ | psychological problems/depression |
| _____ | _____ | degenerative muscle/nerve disease |
| _____ | _____ | seizures/convulsions              |
| _____ | _____ | gallbladder disease (now)         |
| _____ | _____ | kidney/bladder infections         |
| _____ | _____ | venereal disease, hepatitis, AIDS |
| _____ | _____ | bleeding disorder/hemophilia      |
| _____ | _____ | thyroid trouble                   |
| _____ | _____ | blood clots                       |
| _____ | _____ | artificial joints                 |
| _____ | _____ | tuberculosis                      |
| _____ | _____ | history of polyps                 |
| _____ | _____ | Prosthetic heart valve            |
| _____ | _____ | Mitral valve prolapse             |

**PREGNANT:** \_\_\_\_\_ (yes)

Other Medical Illness: \_\_\_\_\_

**Are you allergic to Latex \* ?** \_\_\_\_\_

**\* OTHER ALLERGIES ON MEDICATION RECORD**

**Do you have a pacemaker?** \_\_\_\_\_

**Do you have an internal defibrillator?** \_\_\_\_\_

**PREVIOUS OPERATIONS**

|   |             |  |             |
|---|-------------|--|-------------|
| <b>Operation</b>                            | <b>Date</b> | <b>Operation</b>                           | <b>Date</b> |
| <input type="checkbox"/> Prostate surgery   | _____       | <input type="checkbox"/> Joint replacement | _____       |
| <input type="checkbox"/> Open heart surgery | _____       |  |             |
| <input type="checkbox"/> Hysterectomy       | _____       | <b>Other Operations</b>                    | <b>Date</b> |
| _____                                       |             | <input type="checkbox"/> _____             | _____       |
| <input type="checkbox"/> Complete           | _____       | _____                                      |             |
| <input type="checkbox"/> Partial            | _____       | <input type="checkbox"/> _____             | _____       |
| <input type="checkbox"/> Cancer             | _____       | _____                                      |             |
| <input type="checkbox"/> Colon surgery      | _____       | <input type="checkbox"/> _____             | _____       |
| <input type="checkbox"/> Polypectomy        | _____       | _____                                      |             |
| <input type="checkbox"/> Hernia repair      | _____       |  |             |

**HAVE YOU HAD PREVIOUS COLON EXAMS:**

|                              |            |              |
|------------------------------|------------|--------------|
| _____ Flexible Sigmoidoscopy | Date _____ | Doctor _____ |
| _____ Colonoscopy            | Date _____ | Doctor _____ |
| _____ Barium Enema           | Date _____ | Doctor _____ |
| _____ Other _____            | Date _____ | Doctor _____ |

**FAMILY HISTORY:** Please list your family history. Yes if living, No if deceased. Please list the family member's present age or age at death.

|          | <b>Living?<br/>YES/ NO</b> | <b>Age<br/>(yrs)</b> | <b>History of Colon<br/>or colon or<br/>rectal cancer?</b> | <b>List Other Medical Conditions<br/>or Rectal polyps<br/>(Diabetes, heart disease, or cause of death)</b> |
|----------|----------------------------|----------------------|--|--|
| FATHER   | _____                      | _____                | _____  | _____  |
| MOTHER   | _____                      | _____                | _____  | _____  |
| BROTHER  | _____                      | _____                | _____  | _____  |
|          | _____                      | _____                | _____  | _____  |
| SISTER   | _____                      | _____                | _____  | _____  |
|          | _____                      | _____                | _____  | _____  |
| CHILDREN | _____                      | _____                | _____  | _____  |
|          | _____                      | _____                | _____  | _____  |
| OTHER    | _____                      | _____                | _____  | _____  |
|          | _____                      | _____                | _____  | _____  |

*To the best of my knowledge, all the information listed on my medical history form and medications records are correct.* **Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I have reviewed with the patient/patient representative  
**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**Consent to Release Information.**

I authorize OVCRS to discuss and release medical information regarding my care and scheduled procedures to the following family members in specific:

|       |              |       |
|-------|--------------|-------|
| _____ | _____        | _____ |
| Name  | Relationship | Phone |
| _____ | _____        | _____ |
| Name  | Relationship | Phone |
| _____ | _____        | _____ |
| Name  | Relationship | Phone |

**EMERGENCY CONTACT PERSON**/who does not live with you: Name \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Notification of Ownership**

**I acknowledge** that I have been informed of my physician's joint ownership with community physicians and Seaton Health (a St. Mary's affiliate) of Surgicare Outpatient Surgical Center, a center providing excellent cost-effective care and convenience. I have been informed **I am free to request services be scheduled at another facility**, should I prefer.

**Authorization to Treat**

**I authorize examination and treatment** by Ohio Valley Colon & Rectal Surgeons, Inc. (OVCS), and providers employed by OVCS.

**Acknowledgement of this Document**

By my signature, I acknowledge that I have read and received the **Authorization, Assignment, Consent, Notifications, Rights and Responsibilities for Patients at Ohio Valley Colon & Rectal Surgeons, Inc.** as contained on this form, and received a copy of **OVCRS Notice of Privacy Practices.**

|  |       |
|--|-------|
| _____  | _____ |
| Patient or authorized representative signature | Date  |

\*\*\*\*\*

**Medicare Patients Only**

**I request that payment of authorized Medicare benefits be made** either to me or on my behalf for any services furnished me by or at Ohio Valley Colon & Rectal Surgeons, Inc, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agent's information needed to determine these benefits or any benefits for related services.

|   |       |
|---|-------|
| _____   | _____ |
| Medicare Patient or authorized representative signature | Date  |



## Payment Policy and Agreement

Patient: \_\_\_\_\_

Chart #: \_\_\_\_\_

Dr: Waller          Smith          Chilukuri          Arruffat

Our commitment to our patients is to provide quality, affordable healthcare. In order to succeed we need your assistance and understanding of our payment policy.

You will be financially responsible for all charges on your account with *Ohio Valley Colon & Rectal Surgeons*, including but not limited to, co-payments, co-insurance, non-covered services, and deductibles. **Insurance co-payments are due at check-in on the date of service.**

As a courtesy, *OVCRS* will contact your insurance company to obtain Authorization, or Pre-certifications for procedures scheduled by our office. Please remember that authorization or pre-certification **does not guarantee coverage with your insurance**. It is the patient's responsibility to contact the insurance carrier prior to all services rendered, for determination of benefits and to know and understand the expected out of pocket expenses you may occur.

**Patients with high deductible plans, \$1000 or more, will be expected to pay a portion of approved fees prior to services rendered.**

Routine screening procedures will be expected to pay ½ of approved charges and non-routine procedures will be expected to pay 1/3 of approved charges. You will be contacted by our business office if prepayment is required. There will be facility charges in addition to the physician's fee for all procedures done outside *OVCRS* office. **The patient is responsible for making separate arrangements with the facility for payment of those charges.**

**Uninsured/self-pay** patients will be asked to make payment in full unless prior arrangements are made in advance of services rendered. Please ask to speak to a member of our insurance staff to inquire about payment options that are available. **We do offer some interest free financing options for patients that qualify.**

**Disability/Family Medical Leave Act** forms will be filled out for the **Patient** at no cost. Any additional forms for patient or family members will be charged a fee of \$5.00 per form.

We accept cash, check, MasterCard and Visa. You will receive a monthly statement on your account for any balance due and payment is expected upon receipt of statement. If payment is not received on account within 60 days, collection process may be initiated.

### Payment Agreement

As the Patient or Patient Authorized Representative and Responsible Party, I hereby understand the payment policy and agreement set forth by *OVCRS*. I also request that payment of authorized insurance benefits (including, but not limited to Medicare, Medicaid, HMO, PPO, BC/BS and Workers Compensation) be made on my behalf to *OVCRS* for any services furnished to me by physicians or employees of *OVCRS*. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. I request that any other insurance benefits be paid directly to *OVCRS*. I authorize *OVCRS* to submit claims to my insurance carriers or their intermediaries for all services rendered by *OVCRS*. I authorize the release of any information required to process any claims.

I understand that I am financially responsible for all balances regardless of insurance coverage, if any, subject to Federal Law concerning payment for services provided to Medicare beneficiaries. I also agree to be responsible for reasonable attorney's fees, court costs and other collection expenses incurred by *OVCRS* in connection with collection of amounts due.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Patient Signature/Patient Authorized Representative

Date: \_\_\_\_\_