McConnell Colorectal Center
Elizabeth J McConnell, MD

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX ☐ MALE ☐ FEMALE

HOME PHONE #	WORK PHONE #	CELL PHONE #	MARRIED STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

SPOUSE NAME:	SPOUSE DOB:

RACE
☐ AFRICAN AMERICAN ☐ ASIAN ☐WHITE ☐ DECLINE

ETHNICITY
☐ CENTRAL AMERICAN ☐ CUBAN ☐ DOMINICAN ☐ HISPANIC/LATINO
☐ MEXICAN ☐ NOT HISPANIC/LATINO ☐ PUERTO RICAN ☐ DECLINE

EMAIL ADDRESS

REFERRING PHYSICIAN NAME (ADDRESS AND PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY, STATE	ZIP	WORK PHONE

EMPLOYER	OCCUPATION

EMPLOYER ADDRESS	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PATIENT EMPLOYMENT INFORMATION (if other than responsible party)

PATIENT'S EMPLOYER	OCCUPATION	WORK RELATED ☐ YES ☐ NO

EMPLOYER ADDRESS	CLAIM # FOR WORKER'S COMP/ICA

ADDRESS	CITY, STATE	ZIP	DATE OD INJURY

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO – OTHER THAN SPOUSE	RELATIONSHIP

ADDRESS	CITY, STATE	ZIP	PHONE NUMBER

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

WAS YOUR INSURANCE PURCHASED THROUGH THE HEALTHCARE EXCHANGE (OBAMACARE)? YES/NO
(WE ASK THIS QUESTION TO INSURE PROPER HANDLING OF YOUR CLAIM.)

PRIMARY INSURANCE	**SUBSCRIBER NAME**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY, STATE	ZIP	PHONE NUMBER

SECONDARY INSURANCE	**SUBSCRIBER NAME**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY, STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
I understand I am financially responsible for services rendered regardless of insurance or other third party payer. Unpaid balance subject to collection fees of 30%, as well a
fees if applicable.

I hereby authorize direct payment to McConnell Colorectal Center of any medical benefits payable to me for the services provided at McConnell Colorectal Center.
I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be res
for the unpaid balance due any bills if this is not done.

X_____
Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE
I hereby authorize McConnell Colorectal Center to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance c
This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____
Patient Signature or Signature of Guardian or Parent Date

INFORMATION CONFIRMED BY STAFF: _____ **INSURANCE CARD SCANNED:_____**

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6245 N 16th Street
Phoenix, Arizona 85016

20325 N 51st Avenue Suite 102-104
Glendale, Arizona 85308

Tel (602) 253-4271
Fax (602) 253-4273

Today's date: _____ Name: _____

DOB: ____/____/____ Age: _____ Height: _____ Weight: _____

Primary Care Physician :_____ (MD/DO/PA/NP)

Referring physician:_____ (MD/DO/PA/NP)

What pharmacy do you currently use (name and cross street)? _____

1. Why are you being referred to us?

---

2. Are you currently having any of the following symptoms?

Change in Bowel Patterns

☐ Blood in stool ☐ Dark stool
☐Diarrhea ☐ Constipation

Other Symptoms

☐ Rectal bleeding
☐ Rectal pain
☐ Rectal drainage
☐ Pain with bowel movements
☐ Incontinence gas/stool/urine
☐ Liquid or mucus
☐ Anal itching/burning/irritation
☐ Abdominal pain
☐ Hemorrhoids
☐ Mass palpable with wiping
☐ History of colon polyps
☐ Family history of colon cancer
Age of dx _____

3. Medical History:

☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ High Cholesterol
☐ Seizures ☐ Heart disease ☐ Stroke ☐ Diverticulitis
☐ Gout ☐ Liver disease ☐ Hepatitis ☐ Anxiety Disorder
☐ Bleeding Disorder ☐ Thyroid Disorder ☐ HIV ☐ GERD/Reflux
☐ Anal warts/HPV ☐ Herpes ☐ Viral exposure ☐ COPD
☐ Cancer (What type?) _____ ☐ Other _____

Have you had a recent:

Electrocardiogram (ECG): Date: _____
Colonoscopy: Date: _____
Flexible Sigmoidoscopy: Date: _____
Barium Enema: Date: _____

4. Surgical history:

Procedure	Date	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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5. Medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Medication allergies: Yes No If yes, which meds: _____
7. Smoking status: Yes No If yes, how much: _____
8. Illicit/recreational drug use: Yes No If yes, which drug: _____
9. Caffeine: Yes No If yes, how much per day: _____
10. Alcohol: Yes No If yes, how much per week: _____

10. Are you on anticoagulant therapy/medication: _____

11. Family history

Please indicate your family history:

	Colon polyps	Colon cancer	Ulcerative colitis/crohn's disease	Other cancers (breast, ovarian, gastric, etc) Medical History of diabetes, high blood pressure, ect
You				
Mother				
Father				
Sister (s)				
Brother (s)				
Daughter (s)				
Son (s)				

Please indicate father's or mother's side of the family:

	Colon polyps	Colon cancer	Ulcerative colitis/ crohn'sdisease	Other cancers (breast, ovarian, gastric, etc)
Grandmother	F M	F M	F M	
Grandfather	F M	F M	F M	
Aunt (s)	F M	F M	F M	
Uncle (s)	F M	F M	F M	

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_____
Patient Name

Do you have a history of?

CARDIAC:

Heart attack? ☐ Yes ☐ No _____
Heart Failure? ☐ Yes ☐ No _____
Valve problems? ☐ Yes ☐ No _____
Abnormal heart rhythm? ☐ Yes ☐ No _____
Pacemaker/defibrillator? ☐ Yes ☐ No _____
Heart medications? ☐ Yes ☐ No _____
Poor circulation to legs? ☐ Yes ☐ No _____

NEUROLOGICAL:

Stroke or TIA (mini stroke)? ☐ Yes ☐ No _____
Spinal cord injury or problems? ☐ Yes ☐ No _____
Chronic muscle weakness? ☐ Yes ☐ No _____

PULMONARY:

Emphysema/chronic bronchitis? ☐ Yes ☐ No _____
Smoking? ☐ Yes ☐ No How much? _____ How long? _____
Asthma? ☐ Yes ☐ No _____
Use of oxygen at home? ☐ Yes ☐ No _____

GENERAL:

Diabetes? ☐ Yes ☐ No Controlled by insulin? ☐ Pills? ☐ or diet? ☐
Sleep apnea? ☐ Yes ☐ No _____
Cirrhosis of the liver? ☐ Yes ☐ No _____
Kidney disease or dialysis? ☐ Yes ☐ No _____
Other significant medical
Problems? (If so, please list) _____

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GENERAL CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Patient's Performing or Supervising Physician: _____

Billable procedure(s) that **MAY** be performed if necessary, by the above Surgeon/Physician at the **McConnell Colorectal Center if** it applies to your condition:

- ☐ **Anoscopy (rectal exam)**
- ☐ **Incision and drainage of abscess**
- ☐ **Evacuation of thrombosed hemorrhoid**
- ☐ **Removal of skin tag**
- ☐ **Banding of hemorrhoid**

This consent form is designed to give permission for either physician in the practice to perform any of the above procedures during the exam if necessary.

1) The McConnell Colorectal Center maintains personnel and facilities to assist the physician and surgeons in their performance of various surgical operations and other special diagnostic procedures. These procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes and no warranty or guarantee is made as to result or cure.
2) The patient's physician/surgeon may recommend the procedures set forth above to be performed, together with any other procedures which in the opinion of the performing physician may be indicated due to an emergency during the course of the procedure. The procedures may also involve the service of pathologists, who are performing designated duties and are performing such duties in the course of treatment as independent contractors.
3) I consent to the disposal of any organ, tissue sample, member or other item removed from my person during the procedure described above.
4) I understand I may be transferred to the nearest admitting hospital in the event of a life-threatening emergency.
5) In the event that an employee or physician has an accidental needle stick or mucous membrane exposure to my blood or body fluid during the course of my care I consent to a blood sample to be used for testing of HIV or other communicable disease.
6) Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.
7) Acknowledgments: I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.
8) **Consent to Procedure(s) and Treatment:** Having read this, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) I have marked above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted trained persons as well as the presence of observers. I also understand that all of the procedures perform are billable procedures.

_____ _____
Patient Signature (or person authorized to sign for patient) Date

_____ _____

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Witness Printed Patient's Name

Authorization to Use or Disclose My health Information

Patient name: _____ Date of birth_____

Previous name: _____

My Authorization:

You may use or disclose the following health care information (check all that apply)

○ All my health information including, but not limited to , AIDS/HIV and Other Communicable Disease Information, Behavioral health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted:
_____

○ My health information relating to the following treatment or condition:_____

○ My health information for the date(s):_____

To:

Name: _____

Address: _____

City, State, Zip_____

You may disclose my healthcare information to:

Name: **Elizabeth McConnell MD**

Address: **6245 North 16th Street**

Phoenix, AZ 85016

Fax: **(602) 253-4273**

Date: _____ Signature: _____

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Contact Information

I may be contacted in the following manner (circle all that apply):

OK to leave message with detailed information: Home Work Cell No

Information may be left with me or the following individuals:

____Spouse Name & birthdate_____

____Other Name & birthdate_____

Office Policies

Medical Records **Initial**

When requesting copies of your medical records please allow 48-72 business hours to process. _____

Disability Forms

There will be a $20.00 completion and processing fee for all forms needing to be completed related to disability. **Please also allow 5-7 business days for these to be completed.** _____

Office Cancellation/Reschedule

If you cancel or reschedule an office visit more than 2 times without notifying our office at least 24 hours in advance, you will be released from our practice and we will no longer be able to provide care for you. _____

Surgery Cancellation/Reschedule

If you are scheduled for a procedure or surgery of any kind and you need to reschedule or cancel your scheduled procedure, you will be subject to a $50.00 rescheduling/cancellation fee. _____

Acknowledgement of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name Relationship (self, parent , legal guardian, etc)