



San Antonio Colon and Rectal Clinic

REGISTRATION FORM

(Please Print)

Today's Date: _____

PATIENT INFORMATION					
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms/Miss	Patients Last Name:	First Name:	Middle:	Marital Status (circle one): Single / Married / Divorced / Widowed	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what is your legal name?		Date of Birth:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address / PO Box:		City:	State:	Zip Code:	
Social Security Number:		Home Phone Number: ()	Alternate Phone Number: ()		
Employer / Occupation:			Employer Phone Number: ()		
Family Physician / PCP:			Family Physician / PCP Telephone Number: ()		
How did you hear about us: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____					
Referred By: <input type="checkbox"/> Dr _____ <input type="checkbox"/> Family / Friend _____					

INSURANCE INFORMATION			
(please give insurance card to receptionist)			
Responsible Party (in not pt)	Responsible Party Address (if different):		Responsible Party No: ()
Primary Insurance Name:	Policy Number:	Group Number:	
Policy Holder's Name (if not patient):	Policy Holder's Date of Birth:	Policy Holder's S.S. Number:	
Patients Relationship to Policy Holder (if not self):			
Secondary Insurance Name:	Policy Number:	Group Number:	
Policy Holder's Name (if not patient):	Policy Holder's Date of Birth:	Policy Holder's S.S. Number:	
Patients Relationship to Policy Holder (if not self):			

IN CASE OF EMERGENCY			
Name of local relative or friend:	Relationship to Patient:	Telephone Number: ()	Alternate Number: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balances. I also authorize San Antonio Colon and Rectal Clinic or my insurance company to release any information required to process my claims.

Patient/Gaurdian Signature

Date



SAN ANTONIO COLON AND RECTAL CLINIC

Medical History

Name: _____ DOB: _____ Date: _____

Describe your symptoms. (What brought you to the doctor?)

Are you presently taking any of the following medications?

(Please Circle Yes or No)

YES	NO	Aspirin, Anacin, Buffering	YES	NO	Tranquilizers
YES	NO	Heart or High Blood Pressure Pills	YES	NO	Diet Pills
YES	NO	Cortisone	YES	NO	Blood Thinning Pills
YES	NO	Cough Medicine	YES	NO	Dilating
YES	NO	Hormones	YES	NO	Water Pills (Diuretics)
YES	NO	Insulin or Diabetic	YES	NO	Antibiotics
YES	NO	Iron	YES	NO	Birth Control Pills
YES	NO	Laxatives	YES	NO	Sleeping Pills
YES	NO	Thyroid Medicine	YES	NO	Nerve Pills

Others: _____

List any allergies to any medicines: _____

List any operations including dates: _____

Previous X-Rays:

Colon, Barium Enema	_____	Date: _____	Location _____
Gallbladder	_____	Date: _____	Location _____
G.I. Series	_____	Date: _____	Location _____
Kidney	_____	Date: _____	Location _____

Family History of Cancer:

- Cancer _____
- Diabetes _____
- Heart Attack _____
- Bleeding Tendencies _____
- Colitis _____
- Colon and Rectal Cancer _____
- Polyps _____

Date of your last Physical Exam? _____

By What Doctor: _____



SAN ANTONIO COLON AND RECTAL CLINIC

Medical History

Name: _____ DOB: _____ Date: _____

Do you have any of the following problems? (Circle YES or NO)

- YES NO Rectal Bleeding YES NO Mucus in Stool
YES NO Rectal Pain YES NO Ribbon like Stools
YES NO Rectal Fullness YES NO Change in Bowel Habits
YES NO Rectal Itching YES NO Constipation
YES NO Rectal Discharge YES NO Requires of Laxatives
YES NO Rectal Burning YES NO Require Enemas
YES NO Rectal Protrusion

CARDIOPULMONARY

- YES NO Chest Pains
YES NO Shortness of Breath
YES NO High Blood Pressure
YES NO Severe Cough
YES NO Heart Problems
YES NO Tuberculosis

GASTROINTESTINAL

- YES NO Abdominal Pain
YES NO Abdominal Cramps
YES NO Nausea or Vomiting
YES NO Indigestion
YES NO Gas or Distention
YES NO Stomach Ulcers

GENITOURINARY

- YES NO Kidney Problems
YES NO Burning during urination
YES NO Frequency of urine
YES NO Blood in urine

GENERAL

- YES NO Diabetes
YES NO Headaches
YES NO Dizziness
YES NO Epilepsy

SOCIAL HISTORY

- YES NO Do you smoke. For how long? _____
YES NO Do you drink more than 6 cups of coffee per day.
YES NO Do you regularly drink alcohol. How much? _____

What type of work do you do? _____

ANSWER ONLY IF WOMEN:

- How many pregnancies? _____ Miscarriages _____
Is your period regular _____ Irregular _____
Date of last Pap smear: _____



San Antonio Colon and Rectal Clinic

Jaime L. Mayoral, MD, FACS Mario A. Alcantara, MD Tamara J. Merchant-McCambry, MD
Matthew L. Voth, MD J.Chris Connaughton, MD

I, _____ authorize the release of my entire Medical Records
(Print Name/Nombre)

To: **San Antonio Colon and Rectal Clinic.**

Please send all information contained in my medical records, including my insurance information by (check one):

- Fax: **(210)** _____
- Mail: (list address) _____

San Antonio, TX

Signature: _____ Date of Birth: _____

SS#: _____

Today's Date: _____ Expiration Date: **NEVER**

OFFICE USE ONLY:

I, _____ completed the above patients request for medical records on ____/____/20 ____ by (circle one): FAX / MAIL

Signature: _____ Date: _____



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Previous Name: (if applicable) _____ SS#: _____

I request and give authorization to **San Antonio Colon and Rectal Clinic**
to release my medical information to the following people:

<p>Name: _____</p> <p>DOB: _____ Relationship: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p>
<p>Name: _____</p> <p>DOB: _____ Relationship: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p>

This request and authorization applies to:

(PLEASE CHECK ALL THAT APPLY BELOW)

- Medical information relating to the following treatment, condition, or dates: _____
- _____
- All Medical information
- Other: _____

****This authorization remains in effect until patient notifies San Antonio Colon and Rectal Clinic in writing****

Patient Signature: _____ Date: _____

1200 Brooklyn Ave. Ste# 150 San Antonio TX 78212 Tel: 210-212-4114 Fax: 210-212-4012
2829 Babcock Rd. Ste# 625 San Antonio TX 78207 Tel: 210-298-7501 Fax: 210-298-7505
3338 Oakwell Ct. Ste# 207 San Antonio TX 78218 Tel: 210-298-3050 Fax: 210-298-3056
11212 Hwy 151 Ste# 290 San Antonio TX 78251 Tel: 210-298-5250 Fax: 210-298-5255
502 Madison Oak Ste# 160 San Antonio TX 78258 Tel: 210-593-4020 Fax: 210-404-9965



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ATTN: All Patients

In order for our physicians to better examine you during your visit a **Diagnostic Anoscopy** may be performed in the office. A Diagnostic Anoscopy is a small scope that is used to assist your physician during the physical exam to diagnosis any conditions you may have. Depending on your condition, a Diagnostic Anoscopy may be needed at each visit.

Please be aware that for MOST insurance companies, a Diagnostic Anoscopy is considered an invasive diagnostic procedure. **Invasive diagnostic procedures are considered outpatient surgical procedures and are subject to your deductible, copayment, and coinsurance.**

We encourage each of our patients to take an active role in knowing your insurance benefits. However, we appreciate that insurance benefits can be difficult to understand; therefore our staff is here to assist you if you have any questions regarding your insurance benefit coverage.

Thank You,
Your Physicians and Staff

ATTN: Todos los pacientes

Para que nuestros médicos mejoren su diagnostico durante su visita un examen diagnostico de Anoscopia puede ser realizado durante su visita. Un examen diagnostico de Anoscopia es un pequeño alcance que se utiliza para asistir a su médico durante el examen físico para ayudar a diagnosticar cualquier condición que usted pueda tener.

Dependiendo de su condición, un examen diagnostico de Anoscopia puede ser necesario en cada visita.

Porfavor sea consciente que para LA MAYORÍA de las compañías de seguros, el examen diagnostico de Anoscopia está considerado como un procedimiento de diagnóstico invasor. La mayoría de los procedimientos diagnóstico invasores se consideran los procedimientos quirúrgicos y están basados a su deducible, copayment, o coaseguro. Le pedimos a cada uno de nuestros pacientes informarse bien sobre la cobertura de su seguro medico. Sin embargo, comprendemos que las coberturas de seguro pueden ser difíciles de entender, por lo tanto nuestro personal está aquí asistirles por si tiene alguna pregunta con respecto a su cobertura medica.

Gracias,
Your Physicians and Staff

I have read and understand the above information

Patient Signature

Date



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Attn: All Colonoscopy Patients

There has been some recent confusion between a screening colonoscopy and a diagnostic colonoscopy. It is important for you to understand the difference for billing and insurance purposes.

A **screening colonoscopy** is performed on a patient who does not have any symptoms prior to the colonoscopy and there are no significant findings during the examination. A screening colonoscopy is typically performed on patients age 50+ and patients who are at high risk for developing colon cancer.

A **diagnostic colonoscopy** is performed on a patient to evaluate and diagnose signs and symptoms that are already present prior to the colonoscopy.

For most insurance companies, including Medicare, deductibles are waived for screening colonoscopies. However, according to Medicare guidelines if a lesion, growth, or polyp is detected and results in a biopsy or lesion/growth removal during the screening colonoscopy, the charge code must be changed to a diagnostic colonoscopy. Payments will now be made under the diagnostic colonoscopy guideline, which means the patient is responsible for any deductibles, coinsurances, and co pays associated with the colonoscopy.

Unfortunately, for patients who present no symptoms, it is impossible to determine if a screening colonoscopy will result in the detection of a lesion or polyp. Please be aware that although we are scheduling you for a screening colonoscopy in the end we may have to bill for a diagnostic colonoscopy.

We encourage our patients to be knowledgeable about your insurance coverage of colonoscopies. However, we realize that insurance policies can be difficult to understand; therefore, our staff is available to answer any questions you may have regarding screening or diagnostic colonoscopies.

Thank you,

The San Antonio Colon and Rectal Clinic
Physicians and Staff

I have read and understand the above information.

Patient Signature

Date

Revised 2/5/09

1200 Brooklyn Ave., # 150, San Antonio TX 78212, Tel: 210-212-4114, Fax: 210.212.4012
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Acknowledgement of Receipt of the Notice of Privacy Practice

I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date



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FINANCIAL POLICY

The doctor and staff of the San Antonio Colon & Rectal Clinic are dedicated to giving the best possible medical care that can be provided. We want to serve you in a friendly and caring manner. You are important to us. With this in mind, we would like to explain our policy to you.

1. If you have insurance, we will file a complete insurance claim form with your insurance company.

a) You will be expected to pay any co-pay and unfulfilled deductible, or out-of-pocket expense, as your policy dictates at the time of your visit to our office and before surgery is performed.

b) We automatically file all Medicare/Medicaid, Blue Cross/Blue Shield PPO and HMO claims.

2. If you do not have insurance coverage, we ask that you pay for your office visit and any procedures at the time of service.

There are three ways in which you may pay:

1. Cash
2. Check
3. Credit Card (Visa or MasterCard)

3. Should you need surgery, you will be asked to speak with one of our Patient Representatives to make payment arrangements.

4. If for any reason your account is not paid in a timely manner and must be turned over to an outside agency for collection any expense charged by that agency will be added to the balance of your account. (We feel this action can be avoided with proper communication and an understanding of our financial policy.)

I have read and understand the above information:

Patient Signature

Date

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Please list all Doctors and Specialists you are currently seeing.

Dr. Name: _____
Specialty: _____
Phone#: _____
Fax #: _____
Address: _____

Dr. Name: _____
Specialty: _____
Phone#: _____
Fax #: _____
Address: _____

Dr. Name: _____
Specialty: _____
Phone#: _____
Fax #: _____
Address: _____

Dr. Name: _____
Specialty: _____
Phone#: _____
Fax #: _____
Address: _____

****IF ADDITIONAL PAGE IS NEEDED
PLEASE ASK FOR ANOTHER ONE****