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Locations in Nassau, Suffolk and Queens

Patient's Name _____*Date of Birth*_____

Home phone # _____ *Cell Phone #*_____

*Today's date*_____

How did you hear about our practice? *(check all that apply)*

____ Referred by provider. Provider's name _____

____ Internet Search. Did you visit our website? Yes ____ No____

____ Family member or friend. Family member or friend's name_____

What is the reason for today's visit? _____

Date of your last colonoscopy? _____

ARE YOU CURRENTLY TAKING? BLOOD THINNERS: YES____ NO ____ ASPIRIN: YES____ NO____

HEIGHT _____ WEIGHT _____lbs.

Past Medical History (check all that apply)

_Abdominal Aortic Aneurysm
_Amenorrhea
_Asthma
_breast cancer
_CAD (Any Cardiac Issues?)
_CHF
_clotting disorder
_COPD
_AIDS
_Arthritis
_bleeding disorder
_bruising tendency
_cervical cancer
_Cholangiocarcinoma
_colon cancer
_Crohn's Disease

_Diabetes Mellitus _DVT

_dysplasia Cervix _Gastric Cancer

_GERD _Heart Murmur

_hepatitis B _Hepatitis C

_Hepatocellular Cancer _Hernia

_HIV _HPV

_Hx Ovary Malignancy _Uterine Malignancy

_Hypercholesterolemia _Hypercoagulative state

_Hyperlipidemia _Hypertension

_Hypothyroidism _Lupus

_Obstructive Sleep Apnea _Osteoarthritis

_Osteopenia _Osteoporosis

_Ovarian cancer _Ovarian Cysts

_peptic ulcer disease _peripheral vascular disease

_poorly controlled hypertension _post menopausal

_prostate cancer _pulmonary embolism

_rectal cancer _renal insufficiency

_renal stones _rheumatoid arthritis

_sleep apnea _Other

Past surgical history- (If yes, please indicate year)

_appendectomy _breast biopsy

_breast lumpectomy _Cardiac Surgery

_cesarean section _cholecystectomy, open

_cholecystectomy, laparoscopic _gastrectomy

_colectomy _hip replacement

_hernia repair _knee surgery

_hysterectomy _liver resection

_Liver lobectomy _salpingo-oophorectomy

_mastectomy _wrist surgery

_shoulder surgery _Other

Family History-

Please write below to report problems your family members might have had and the family members with the problem, e.g. “Father with colon cancer.”

_____ _____

_____ _____

_____ _____

Social History (Please check all that apply)

Smoking Status: YES_____ No_____

If yes, what type: Cigarette _____Pipe____ Cigar____ Start Date_____

Former Smoker_____ Date Quite _____

Smokeless Tobacco_____Current_____Former_____NeverUsed_____Snuff_____Chew_____

Never Smoked _____

Alcohol Use:

How often do you have a drink containing alcohol?

Never____ Monthly or less_____2-4 times a month_____2-3 times a week_____

4 or more times a week _____patient refused_____

How many drinks containing alcohol do you have on a typical day when you are drinking?

_____

How often do you have six or more drinks on one occasion?

Never_____ Less than monthly_____ Monthly _____ Weekly_____

Daily or almost every day_____ Patient Refused_____

Current Medications (Please include the name, dosage and frequency of the medication)

Medication	Dosage	Frequency

Do you have any medication allergies?

Name of Medication	Reaction

Do you have any other allergies? Please indicate what you are allergic to and the reaction.

Allergy	Reaction

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

I authorize the release of information including the diagnoses, records, examination results medications dose changes, and claims information.

This information may be released to:

- Spouse: _____
- Child(ren): _____
- Other: _____
- *Information is not to be released to anyone other than me.*

Messages

Please call - my home phone _____ or my cell phone_____.

If unable to reach me:

- *You may leave a detailed message* ***OR***
- *Please leave a message asking me to return your call*
- *Do not leave messages*

The best time to reach me is (day of week) _____between (time) _____.

This Release of Information will remain in effect until terminated by me in writing. The release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ___/___/___

Your consent choice on this form will apply jointly to all four platforms. You may change your decision at any time in the future by completing a new form. **Please completely fill in only one choice out of the following 4 options**:

○ **I GIVE CONSENT** to all of the Participants listed on the Mount Sinai HIE website to access my health information stored in the Mount Sinai HIE, to all of the Participants listed on the Epic and Carequality websites to access all of my MSHS electronic medical records, and to all employees, agents and members of the medical staff of MSHS to access all of my electronic health information available through Healthix in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services and emergency care.

○ **I DENY CONSENT, EXCEPT IN A MEDICAL EMERGENCY**, to all of the providers listed on the Epic and Carequality websites to access my Mount Sinai electronic medical records. I also deny consent to all the Participants listed on the Mount Sinai HIE website to access my health information stored in the Mount Sinai HIE, except for information they provided themselves, and to all employees, agents and members of the medical staff of MSHS to access any of my electronic health information available through Healthix contributed by a non-Mount Sinai participant, except in a medical emergency.

I DENY CONSENT, EVEN IN A MEDICAL EMERGENCY, to the Participants listed on the Mount Sinai HIE website to access my electronic health information stored in the Mount Sinai HIE, except for information they provided themselves, and to all employees, agents and members of the medical staff of MSHS to access any of my electronic health information available through Healthix contributed by a non-Mount Sinai participant for any purpose. I also deny consent to the Participants listed on the Epic and Carequality websites to access my MSHS electronic medical record, but **I understand that the Epic Care Everywhere and Carequality Participants may still access my information in an emergency as allowed by applicable law.**

○ **I DO NOT WISH TO MAKE A DECISION AT THIS TIME**. I understand that Epic Care Everywhere and Carequality participants may be able to access information in my MSHS electronic medical record in a medical emergency as allowed by applicable law. MSHS providers may be able to access my information via Healthix in an emergency as allowed by applicable law.

My questions about this form have been answered and I have been given the choice to receive a copy of this form.

Print Name of Patient	Signature of Patient (or Patient's Legal Representative)

Patient Date of Birth	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

516-248-2422
www.CRSSNY.com

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INFORMED CONSENT FOR ANORECTAL PROCEDURES

You may undergo an anoscopy or proctosigmoidoscopy as part of your rectal examination. These tests allow your doctor to look at the inner lining of your anus, rectum and the lower part of the colon. These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions (such as diverticulosis).

You may be treated for one or more of the following conditions:
• Hemorrhoids
• Anorectal lesions
• Anal fissure
• Perirectal abscess

Nature and purpose of proposed treatment
• Removal of painful and /or bleeding hemorrhoidal tissue; treatment of internal hemorrhoids with injection sclerotherapy, rubber band ligation and/or infrared coagulation
• Treatment of infection in perirectal area, with drainage and collection of any pus
• Treatment of anal fissure including anal dilatation
• Removal of anorectal lesions

Risks common to all surgical procedures:
• Injury to a blood vessel or excessive bleeding
• Infection, which may require the use of antibiotics. In rare cases, another procedure may be necessary including exam under anesthesia at the local hospital

Risks and possible complications of the proposed treatment:
• Pain after procedure, which may require the use of pain medication
• Bleeding • Infection that may require the use of antibiotics. In rare cases, another procedure may be necessary
• Recurrence which may require another surgical procedure

I acknowledge and understand that prior to any procedure being performed, more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained. I understand the above information and give my consent to have the described treatment performed.

_____	_____	_____
Print Name	Patient/Guardian Signature	Date