The Colorectal Care Center
of South Florida, LLC

Michael D. Hellinger, M.D., F.A.C.S., F.A.S.C.R.S.
Diplomate, American Board of Surgery
Diplomate, American Board of Colon and Rectal Surgery

New Patient Forms:

In preparation for your first visit with us, we ask that you **print out the forms and fill them out** as best as you can. If you have questions bring the forms with you and we will attend to them during your interview.

You will also need to have 1 fleets enema 2 to 3 hours prior to your scheduled appointment.

Pre-appointment enema is **not** needed if:

- If you had anorectal surgeries within 6 weeks.
- you are planning to have a consultation for a **colonoscopy**.
- Your visit with us is not for an anorectal complaint
-

Please call us if you are uncertain about whether or not you need enema, or if you have any questions or concerns.

Please bring your insurance card and co-payment to your first appointment.
For co-payment, we accept cash, check and major credit cards.

We look forward to seeing you.

2600 SW 3RD AVENUE / SUITE 650 • MIAMI, FLORIDA • 33129
PHONE: 305-858-1515 • FAX: 305-859-9531
WWW.COLONCAREMIAMI.COM

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PATIENT REGISTRATION FORM

☐Dr. ☐Mr. ☐Mrs. ☐ Ms. Name: _____ ☐Jr. ☐Sr.

Age: _____ DOB: _____ SS#: _____ Sex: ☐ M ☐ F Race/Ethnicity: _____

Languages Spoken: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #'s: Home: _____ Work: _____ Cell: _____

Email address: _____ Fax#: _____

Occupation: _____ Employer: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Spouse's name: _____

Emergency contact: _____ Relation to patient: _____

Phone #s: _____

Referred by: _____ Phone: _____

	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of insured:		
Relationship:		
Plan name:		
ID/Policy #:		
Group #:		

CONSENTS/AUTHORIZATIONS

Consent for disclosure of medical information: It is often difficult to speak with patients in person. Therefore, we must have your permission as to how we may communicate with you.

The practice may disclose my medical information in my presence and when I am not physically present, including disclosure by telephone, voice mail, facsimile, e-mail, or standard mail, to the following individuals.

I give permission to the CCCSF to release my medical information to the following individuals:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Signature: _____ **Date:** _____

Consent for Anorectal Examination and Treatment

Part of your evaluation may include an anorectal examination. This may include, but is not limited to:

Digital rectal examination: insertion of a gloved finger into the anal area

Anoscopy: insertion of an instrument into the anus

Proctosigmoidoscopy: insertion of an instrument into the rectum and lower portion of your colon.

For women, with certain conditions, this may also include a limited vaginal examination including

Insertion of a gloved finger into the vagina

Insertion of a speculum to examine the vagina

These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions. During this examination you are also consenting to treatment of certain anorectal conditions including, but not limited to, hemorrhoids, anorectal growths or lesions, and infections.

I understand and consent to a **"MEDICALLY INDICATED ANORECTAL EXAMINATION INCLUDING BUT NOT LIMITED ALL MODALITIES LISTED ABOVE"**. This may be performed by one of our doctors, and/or a designated representative, all of whom will be identified to you in advance. This consent will remain active until I withdraw my consent in writing.

Name: _____Date: _____

Signature: _____

Witness Signature: _____

CONSENTS/AUTHORIZATIONS

Please initial each statement

1. ____**Consent to treat:** I authorize and consent to examination and treatment by the Dr. at the Colorectal Care Center of South Florida (CCCSF). I permit a copy of this authorization and assignment to be used in place of this original.

2. ____**Consent for photographs:** I consent that photos may be taken in conjunction with my medical treatment. These may be used for medical records, medical research, or medical education. I further acknowledge that, other than placement in my medical record, my identity may not be revealed by the actual photos or by descriptive text.

3. **Financial responsibility:** **PAYMENT IS DUE AT THE TIME OF SERVICE:**
   ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

   a. ____ **PROOF OF INSURANCE**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, **it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service.** Failure on our part to collect co-payments and deductibles from patients can be considered fraud. **If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.**

   b. ____**NONCOVERED SERVICES:** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

   c. ____**ADDITIONAL PROCEDURES:** As part of the patient's evaluation by the Doctor, a procedure may be performed that will be billed separately. The patient's insurance company may apply this to their deductible or assign them a second copayment. In this case, the patient will be responsible for these fees.

   d. ____ **HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits.** If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

   e. ____**MINOR PATIENTS:** The parent or guardian accompanying the minor is responsible for payment of services rendered.

   f. ____**SELF PAY:** If you are self pay, or a member of an insurance plan with which we do not participate, you will be responsible for payment in full at the time the services are rendered.

g. ____**PREVENTIVE SERVICES:** Certain services that are initially categorized as preventative or screening, may result in a finding that necessitates treatment of a finding. In this case the procedure may be reclassified as a therapeutic one. In some of these situations you may become responsible for any deductibles, coinsurance, or copayment.

h. ____ **COLLECTION POLICY:** Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

i. ____**OVERDUE BALANCES:** We are more than happy to discuss and arrange a payment plan with you. However, any balances more than 90 days past due will be subject to an 18% annual interest rate.

j. ____**RETURNED CHECKS:** Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

k. ____ **FORMS:** There is a flat fee of $15.00 for each set of forms the office completes on your behalf.

4. ____**Release of data:** I authorize the physician and staff of the CCCSF to release to any third party (such as an insurer or government agency) any medical information and records concerning diagnosis and treatment when requested for determining claim for payment.

5. ____**Insurance assignment:** I authorize direct payment to the CCCSF for medical benefits. Any services for which assignment is not accepted are acknowledged to be my full and complete financial responsibility.

6. ____**Medicare/Medicaid:** I certify that the information given to me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any medical or other information needed in determining a claim for payment for treatment and/or diagnosis to be released to the Social Security Administration, or its intermediaries or carriers. I certify that all insurance payments pertaining to treatment and/or diagnosis may be assigned to the physician treating me.

NOTICE OF APPOINTMENT NO SHOW POLICY: WE MAKE EVERY EFFORT TO REMIND YOU OF YOUR APPOINTMENT OR PROCEDURE. AS LONG AS YOU HAVE PROVIDED US WITH ACCURATE CONTACT INFORMATION, YOU WILL RECEIVE AN EMAIL, TEXT MESSAGE, AND/OR PHONE CALL REMINDER OF YOUR UPCOMING APPOINTMENT. PLEASE BE ADVISED THAT FAILURE TO CANCEL OR OTHERWISE NOTIFY US THAT YOU WILL BE UNABLE TO ATTEND YOUR SCHEDULED APPOINTMENT OR PROCEDURE **24 HOURS IN ADVANCE** WILL RESULT IN **A CANCELLATION FEE**. FOR AN APPOINTMENT THAT WILL BE **EQUAL TO YOUR COPAY OR $25, WHICH EVER IS GREATER. FOR A PROCEDURE THE FEE WILL BE $100.BY SIGNING BELOW I ACKNOWLEDGE RECEIPT OF THESE POLICIES, FULLY UNDERSTAND THE STATEMENTS, CONSENT TO THE CONTENTS, AND AGREE TO PAY ALL FEES ASSSIGNED TO ME AS OUTLINED ABOVE**. **AFTER THE 3rd NO SHOW WE MAY ELECT TO TERMINATE OUR DOCTOR-PATIENT RELATIONSHIP.**

_____	_____	_____
SIGNATURE	NAME	DATE

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FLORIDA FINANCIAL RESPONSIBILTY DECLARATION

As required by Florida Statute 458.320, I have posted a sign in the lobby area as well as providing in writing to you, the following:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. ***YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE****. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.*

I acknowledge that I have received and understand this notice, I understand what malpractice insurance is, and consent to be treated by the physicians of the Colon and Rectal Care Center of South Florida, LLC.

Name: _____

Signature: _____ **Date:** _____

2600 SW 3RD AVENUE / SUITE 650 • MIAMI, FLORIDA • 33129
PHONE: 305-858-1515 • FAX: 305-859-9531

Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic
  - formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html .

Acknowledgement:

By signing below, I acknowledge that I have received and understand this notice of nondiscrimination.

Name: _____

Signature: _____ **Date:** _____

The Colorectal Care Center
of South Florida, LLC

Privacy Notification

This notice describes how we may use and/or disclose your health information and how you may obtain access to it. Please review it carefully, if you have any questions, please ask us.

Each time you are seen in our offices, a record of your visit is created to document what has transpired. We may use this record for treatment. We may disclose this information to doctors or other healthcare providers who are involved in your care. We may also provide your other physicians with copies of various reports that may assist in subsequent treatment. We also may disclose your medical information to other individuals that you have authorized to act on your behalf to assist in caring for you.

We may also use and disclose your medical information so that the treatment and services we provided may be billed to and payment may be collected from you and/or your insurance provider.

Furthermore, we may use and disclose this information in connection with our efforts to remind you of an appointment or scheduled procedure.

We will also disclose your medical information as required to do so by Federal, State, or Local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We will not use or disclose your medical information without your authorization, except as described n this notice.

We reserve the right to change our practices and make new provisions effective fo0r all protected health information we maintain. Upon your request, we will provide you with any revised privacy policy.

If you believe that your rights have been violated, you can file a written complaint with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

Acknowledgement:
I acknowledge that I have been provided with the Colorectal Care Center of South Florida's Privacy policy and that I have read and fully understand its contents.

Signature: _____ **Date:** _____

Printed Name: _____

Witness: _____

Notice of Privacy Practices
The Colorectal Care Center of South Florida, LLC

Patient signature: _____

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Nanci Hellinger
2600 SW 3rd Ave, Suite 650
Miami, FL 33129
Office: (305) 858-1515
Fax: (305) 859-9531

hysician signature:_____ **lew Patient Visit Questionaire**

Date: _____ **Name:**_____ **DOB:**_____ **Age:**_____

Referring Dr.: _____ Phone #: _____

Address: _____

Primary Dr.: _____ Phone #: _____

Address: _____

Gastro-enterologist.: _____ Phone #: _____

Address: _____

Cardiologist: _____ Phone #: _____

Address: _____

Oncologist: _____ Phone #: _____

Address: _____

Other Dr.: _____ Phone #: _____

Address: _____

Pharmacy: _____ Phone #: _____

Address: _____ Fax:_____

Reason for today's visit: _____

_____

Past Surgeries □ None	**Medications** □ None	**Drug Allergies** □ None

Have you ever had any of the following tests performed? If so please state the date and where the test was performed:

□ Colonoscopy: _____ □ Sigmoidoscopy: _____

□ Upper endoscopy: _____ □ Barium Enema: _____

□ Upper GI or Small Bowel X-ray: _____ □ CAT scan: _____

Social History

Do you use any of the following?

Tobacco products: Currently: □Yes □ No Daily Amount:_____ Previously: □ Yes □ No

Alcohol: Currently: □ Yes □ No Daily Amount:_____ Previously: □ Yes □No

Coffee: □ Yes □ No Daily Amount:_____

Recreational/illicit drugs: Currently: □Yes □ No Previously: □ Yes □ NoWhich types: _____

Sexual habits: □ Heterosexual □ Homosexual □ Bisexual Do you practice anoreceptive intercourse? □ Yes □ No

Recently travel abroad: □ Yes □ No Locations: _____

Women only: Ob/Gyn: _____ Phone #: _____

# of pregnancies: ____ # of vaginal deliveries: _____ Do you have vaginal discharge: □ Yes □ No

# of live births: _____ # of Cesarean sections: _____ Do you have regular periods: □ Yes □ No

# of miscarriages:____ # of Episiotomies or tears during delivery: _____ Date of last PAP smear:_____

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Review of Systems

Do you suffer from any of the following illnesses/problems?

□Weight loss How much?_____ Over how long?_____

□Fatigue □Fever □Chills □Sweats

□Anxiety □Depression □Psychiatric disorders

□Glaucoma □Cataracts □Other eye problems

□Ringing in the ears □Hearing loss □Vertigo/Dizziness

□Hoarseness □Frequent sore throat □Sinus problems

□Heart attack □Heart murmur □ Angina

□Heart Disease □Heart attack

□Chest pain □Palpitations □Irregular heart beats

□High blood pressure □Fainting spells

□Swelling in the feet/ankles/legs

□Shortness of breath □Coughing spells □Asthma

□Bronchitis □Emphysema □Wheezing □Pneumonia

□Stomach/abdominal pain □Groin hernia □ Reflux disease

□Heartburn □Stomach ulcers □Hiatal hernia

□Trouble swallowing □Nausea/vomiting □Loss of appetite

□Hepatitis □Jaundice □Liver problems □Gallstones

□Colon/rectal cancer □Colon/rectal polyps □Colitis

□Crohn's disease □Ulcerative colitis □Proctitis

□Diverticulosis □Diverticulitis □Irritable bowel syndrome

□Hemorrhoids □Anal fissure □Anal fistula or abscess

□Pain/burning with urination □Frequent urination

□Difficulty with urination □Blood in the urine □Kidney stones

□Urination frequently at night □Kidney/urine infections

□History of sexually transmitted disease: _____

□Arthritis □Leg pain □Gout □Spine/back problems

□Skin lesions □Rashes

□Seizures □Strokes □Paralysis/weakness □Numbness

□Temporary loss of vision □Memory loss

□Diabetes □Thyroid problems

□Easy bruising/bleeding □Anemia □Previous blood transfusions

□HIV/AIDS □Tuberculosis

□Personal history of cancer—type: _____

_____

_____

□Other illnesses: _____

_____

Physician notes

Michael D. Hellinger, M.D.,

e Colorectal Care Center
outh Florida, LLC

REVIEW OF SYSTEMS

r from any of the following:

□Abdominal pain: How long: _____ □Constant □Intermittent

□Anal/rectal pain: How long: _____ □Constant □Intermittent

□Associated with bowel movements

□Rectal bleeding: How long: _____ □Constant □Intermittent

□With BMs □Bright red □Dark red □Black stool

□On the paper □In the bowl □On/in the stool

□Anal swelling/protrusions

□Anal itching/burning

□Rectal discharge/drainage

□Change in bowel function --Explain: _____

_____

□Normal bowel movements

□Constipation

□Number of BMs per week _____

□Hard stools □Need to push/strain

□Difficulty evacuating/emptying

□The feeling that your rectum does not empty

□Diarrhea: □Watery □Bloody □With mucous #/day _

□Do you require enemas or laxatives? How often? _____

Which ones: _____

□Do you apply medications to the anal area?

Which ones: _____

If you suffer from any of the following, please also complete the incontinence form

□Soilage or staining of your underclothes

□Do you need to rush immediately to the toilet to avoid an accident?

□Uncontrollable BMs or accidents How often? _____

Is it for: □Solid stool □Liquid stool □Gas

□Small amount □Large amount

□ Do you wear a pad or diapers?

Please give the relationship of any relative with the following:

□ None
□ Colon/rectal cancer:_____
□ Colon/rectal polyps:_____
□ Crohn's disease:_____
□ Ulcerative colitis:_____
□ Other cancer:
Relative:_____Type: _____
Relative:_____Type: _____
Relative:_____Type: _____

Physician notes:

I have reviewed and documented the above findings.

Michael D. Hellinger, M.D., F.A.C.S.,
F.A.S.C.R.S.