COLON-RECTAL SURGERY ASSOCIATES, PC
DAVID H. GIBBS MD   VIRGINIA B. WINBURN MD   EDWARD J. JAKUBS MD
PATIENT QUESTIONNAIRE

NAME____
SEX____
DOB____
SSN____
ADDRESS_____________________________________
ADDRESS LINE 2______________________________
ZIP____
CITY____
STATE_______________________________________
HOME PHONE__________________________________
SAME AS MOBILE?_____________________________
MOBILE PHONE________________________________
EMAIL_______________________________________
HOW SHOULD WE CONTACT YOU?__________________
MARITAL STATUS______________________________
HOW DID YOU HEAR ABOUT US?__________________
____

GUARDIAN NAME_______________________________
EMERGENCY CONTACT NAME______________________
EMEREGENCY CONTACT RELATION_________________
EMERGENCY CONTACT PHONE_____________________
EMERGENCY CONTACT MOBILE____________________
NEXT OF KIN NAME____________________________
NEXT OF KIN RELATION________________________
NEXT OF KIN PHONE___________________________
EMPLOYER NAME_______________________________
EMPLOYER PHONE______________________________
OCCUPATION__________________________________
GUARANTOR NAME______________________________
GUARANTOR DOB_______________________________
GUARANTOR ADDRESS___________________________
GUARANTOR ZIP_______________________________
GUARANTOR CITY______________________________
GUARANTOR STATE_____________________________

PHARMACY____________________________________PHARMACY LOCATION__________________________________

LIST THE PROBLEMS TO DISCUSS WITH YOUR DOCTOR (ROUTINE CHECK-UP/NO SYMPTOMS)

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PLEASE LIST OTHER DOCTORS (e.g. SURGEONS, FAMILY PHYSICIAN, ETC.)

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I hereby authorize COLON-RECTAL SURGERY ASSOCIATES, PC (the practice) to release my medical information to all insurance carriers. I also authorize the practice to file all claims to my insurance carriers and payment to be made directly to the physician. I understand that I am responsible for any amount due by agreement with my insurance company. Should my account be turned over to the Collection Agency, I will be responsible for fees associated with collecting patient balance due.

____   ____________________________

Patient/Guardian Signature   Date

I have received a copy of the HIPAA Notice of Privacy Practices. Initials: ____________________________

I authorize the practice to retrieve my Medication History from my pharmacy Initials: ____________________

dlb 9/5/13