west valley
colon & rectal surgery center, llc

Patient Registration Packet

Please fill out completely and accurately. All patient information is confidential.

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Email: _____
DOB: _____ Age: _____ Sex: M F Non-Binary Transgender
SS Number: _____ Employment Status: _____
Marital Status: _____ PCP: _____
Language: _____ Referring Provider: _____
Race: _____ Ethnicity: _____

Pharmacy Information:

Pharmacy Name: _____ Crossroads: _____
Pharmacy Address: _____ City: _____ State: _____ Zip: _____
Pharmacy Phone: _____

Emergency Contact

Please list two emergency contacts.

First Name: _____ Last Name: _____
Phone: _____ Relationship: _____
First Name: _____ Last Name: _____
Phone: _____ Relationship: _____

Release of Information

I permit West Valley Colon and Rectal Center, its physician's and staff to dicuss my health, medical, and/or billing information in person, by telephone, email, and/or fax with the following people listed below.

Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____

Insurance Information

Please provide a copy of your insurance card(s).

Primary Insurance

Disclaimer: It is patient's responsibility to ensure coordination of benefits if patient is covered under more than one plan.

Insurance Name: _____ Are you the subscriber or beneficiary? _____
ID: _____ Group #: _____
Address: _____ City: _____ State: _____ Zip: _____
Insureds Name: _____ DOB: _____ SS#: _____

Secondary Insurance

Insurance Name: _____ Are you the subscriber or beneficiary? _____
ID: _____ Group #: _____
Address: _____ City: _____ State: _____ Zip: _____
Insureds Name: _____ DOB: _____ SS#: _____

Tertiary Insurance

Insurance Name: _____ Are you the subscriber or beneficiary? _____
ID: _____ Group #: _____
Address: _____ City: _____ State: _____ Zip: _____
Insureds Name: _____ DOB: _____ SS#: _____

Patient Initial: _____

Medical History

First Name: _____ Last Name: _____

Reason for Today's Visit: _____

Patient Info

Weight? Height? Feet Inches

Have you had any falls in the last year? YES NO If yes, how many? Injury with fall? YES NO

Health Questionaire

Please check the following that apply to you.

☐ Alcoholism	☐ Cancer (please specify below)	☐ Fibrocystic Breasts	☐ Incontinence(Urinary)
☐ Alzheimers	☐ Cataracts (please specify below)	☐ Fistula	☐ Incontinence(Fecal)
☐ Anemia (Low Iron)	☐ Colonic Polyps	☐ Gallstones	☐ Kidney Disease
☐ Anal Pain/Discomfort	☐ Crohn's Disease	☐ Galucoma	☐ Kidney Stones
☐ Anal Skin Tag(s)	☐ COPD	☐ GERD	☐ Liver Disease
☐ Anal Fissure	☐ Dementia	☐ Heart Attack	☐ Migraines
☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Pneumonia (currently)
☐ Arthritis	☐ Diabetes Type One	☐ High Cholesterol	☐ Prostate Disease
☐ Asthma	☐ Diabetes Type Two	☐ HIV	☐ Psoriasis
☐ Blood Clots	☐ Diverticulitis	☐ Hyperthyrodism	☐ Seizure
☐ Blood Disorder	☐ Eczema	☐ Hypothyrodism	☐ Sickle Cell Disease
☐ Bronchitis (currently)	☐ Emphysema	☐ Headaches	☐ Skin Tags
☐ Colitis	☐ Gastric Ulcers	☐ Urine Infections	☐ Stroke
☐ COVID (currently)	☐ Irregular Heart Beat	☐ Constipation	☐ Tuberculosis
☐ Other:			
☐ Cancer Specify:			

Colon Health Questionaire

Please circle that apply.

Have you ever had a colonoscopy? YES NO If Yes, When? (Date/Year) _____

Name of Provider who performed your colonoscopy? _____

Have you had a flexible sigmoidoscopy? YES NO If Yes, When? (Date/Year) _____

Name of Provider who performed your colonoscopy? _____

Any family members been diagnosised with colon cancer? YES NO Relation: _____

Have you ever had a positive cologaurd? YES NO When? (Date/Year) _____

History of colon polyps? YES NO Retal Bleeding? YES NO

Changes in Bowel Habits? YES NO

Bowel Movements? Per Day _____ Per Week _____

Women Only

Last Menstural Cycle? Date: _____

Children? #: _____

Vaginal Births? #: _____

Vaginal Births Only-Did you tear? YES NO I don't know If Yes: Tear Episiotomy

Mammography Screening? YES NO If Yes, indicate date and results _____

Covid Screening

Have you been covid vaccinated? YES NO If Yes, please provide your vaccine card.

Current Problems

Please check the following that apply to you.

Weight Loss/Gain	YES	☐	NO	☐	Changes in Bowel	YES	☐	NO ☐
Fever	YES	☐	NO	☐	Constipation	YES	☐	NO ☐
Fatigue	YES	☐	NO	☐	Abdmonial Pain	YES	☐	NO ☐
Hearing Change	YES	☐	NO	☐	Diarrhea	YES	☐	NO ☐
Nose Bleeds	YES	☐	NO	☐	Rectal Bleeding	YES	☐	NO ☐
Visual Changes	YES	☐	NO	☐	Dark Stools	YES	☐	NO ☐
Sore Throat	YES	☐	NO	☐	C Diff	YES	☐	NO ☐
Chest Pain	YES	☐	NO	☐	Rectal Pain	YES	☐	NO ☐
Shortness of Breath	YES	☐	NO	☐	Rectal Burning	YES	☐	NO ☐
Wheezing	YES	☐	NO	☐	Rectal Itching	YES	☐	NO ☐
Nausea	YES	☐	NO	☐	Urinary Frequency	YES	☐	NO ☐
Vomitting	YES	☐	NO	☐	Burning	YES	☐	NO ☐
Headache	YES	☐	NO	☐	Blood in urine	YES	☐	NO ☐

Allergies

Latex	YES		NO		If yes, reaction:
Iodine	YES		NO		If yes, reaction:
Contrast	YES		NO		If yes, reaction:
Anesthesia	YES		NO		If yes, reaction:

Medications

Please list all current medications including prescribed and over the counter.

Medication Name	Dosage (mg)	Frequency (daily, tablets, capsules)

Medication Allergies

Medication Name	Reaction

Surgical History

Please check all that apply. Please indicate year that it occured and results.

☐ No Surgical History

☐	Appendectomy	Date:
☐	Breast Surgery	Date:
☐	Gallbladder Removal	Date:
☐	Hernia Repair	Date:
☐	Cardiac Cath	Date:
☐	Pacemaker	Date:
☐	Heart Stent(s)	Date:
☐	Hysterectomy	Date:
☐	Colon/Small Bowel	Date:
☐	Anorectal Surgery	Date:

Cardiac History

☐ No Cardiac History

Who is your cardiologist?

Phone:

When is that last time you seen your cardiologist?

Was it for a routine visit? YES NO Any Testing Performed? YES NO

Social History

Cigarettes	YES		NO			Monthly		Daily		Socially
Marijuana	YES		NO			Monthly		Daily		Socially
Street Drugs	YES		NO			Monthly		Daily		Socially
Alcohol	YES		NO			Monthly		Daily		Socially
Vape	YES		NO			Monthly		Daily		Socially

Family History

Please check all that apply.

☐	Bleeding Problems	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Asthma	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Hypertension	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	High Chlosterol	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Diabetes	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Heart Attack	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Stroke	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Kidney Disease	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Colonic Polyps	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Diverticulitis	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Ulcerateivce Colitis	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Crohn's Disease	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son
☐	Colitis	☐	Father	☐	Mother	☐	Brother	☐	Sister	☐	Daughter or Son